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ABSTRACT

This guide presents methods for community and migrant health centers to attract and keep competent physicians. Strategies for recruiting physicians include planning the recruitment and choosing the right physician. Compensation arrangements should attract and retain competent health providers, provide incentives for productivity and professional development, and be consistent with federal and state laws. Selection of compensation arrangements, provision of financial incentives, and possible fringe benefits to be offered are considered. Nonmonetary considerations that influence a physician's decision to both choose and remain at a particular practice include the range of services provided, availability of peers, ability to participate in decision making, policies for governance and operations, new reimbursement programs, physician compensation arrangements, and the possibility of taking over the practice. The process of negotiating a contract is also described. Selecting the negotiator, ascertaining the physician's needs and wants before negotiation, and conducting negotiations are described. Provision of a contract is discussed, including actual clauses to be used as contract elements, and a sample contract is provided. Appendices provide lists of family practice residency programs in California; medical schools by state; professional journals that carry classified ads; California's medical societies; colleges of osteopathic medicine, and state medical societies by state. (DHP)

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A Guidebook for Community and Migrant Health Centers

40 Steps to Better Physician Recruitment and Retention

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October 1985

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TABLE OF CONTENTS

ACKNOWLEDGEMENTS
INTRODUCTION
PHYSICIAN OUTLOOK

CHAPTER ONE: PHYSICIAN RECRUITMENT 1

SHAPING THE RECRUITMENT PLAN 1
1. Assessing Community Health Needs 2
2. Establishing a Recruitment Committee 3
3. Developing a Job Description 4
4. Preparing a Community Profile 4
5. Paying for Your Recruitment Efforts 5
6. Identifying Recruitment Sources 6

CHOOSING THE RIGHT PHYSICIAN 11
7. Making a Favorable Impression 12
8. Screening the Candidates 12
9. Ensuring a Successful Site Visit and Interview 13
10. Attending to Spouse's and Family's Needs 14
11. Following Up After the Visit 15
12. Bringing the New Physician on Board 15

FOR MORE INFORMATION 16

CHAPTER TWO: PHYSICIAN COMPENSATION 17

13. Assessing the Health Center's Needs and Goals 17
14. Assessing the Physician's Needs and Goals 18
15. Analyzing the Local Market 19
16. Evaluating Compensation Arrangements 20
17. Providing Financial Incentives 25
18. Offering Fringe Benefits 27
19. Minimizing the Cost of Benefits 36
20. Providing Compensation for An Independent Contractor vs. Employee 37
21. Matching the Compensation Arrangement with Administrative Capabilities 39

FOR MORE INFORMATION 40

CHAPTER THREE: SCOPE OF PHYSICIAN PRACTICE 41

22. Providing a Range of Services 41
23. Providing Back-Up for Physicians 43
24. Offering the Opportunity to Participate in Decision-Making 43
25. Designing and Implementing Clear Governing and Operating Policies 44
26. Mitigating the Impact of New Reimbursement Programs . . 45
27. Matching Physician Compensation Arrangements and Health Center Goals 46
28. Reexaming Health Center Ownership 47
29. Boosting Physician Recruitment and Retention 48

CHAPTER FOUR: PHYSICIAN EMPLOYMENT CONTRACTS 49

NEGOTIATING CONTRACTS 49
30. Selecting the Negotiator 49
31. Ascertaining the Physician's Needs and Wants Before Negotiations 49
32. Conducting Negotiations 51
33. Monitoring Negotiations 51
34. Negotiating with Private Practice or NHSC-Obligated Physicians 52

PROVIDING A CONTRACT 53
35. Minimizing Pitfalls of Contracts 54
36. Ensuring Comprehensiveness and Specificity 54
37. Determining the Physician-Health Center Relationship: Employee or Independent Contractor 55
38. Deciding the Parties to the Agreement 56
39. Selecting Contract Elements 56
40. Including Standard Provisions 67

SAMPLE CONTRACT 72

FOR MORE INFORMATION 78

APPENDIX A: FAMILY PRACTICE RESIDENCY PROGRAMS IN CALIFORNIA

APPENDIX B: GEOGRAPHICAL LISTING OF MEDICAL SCHOOLS

APPENDIX C: PROFESSIONAL JOURNALS THAT CARRY CLASSIFIED ADS

APPENDIX D: CALIFORNIA'S MEDICAL SOCIETIES

APPENDIX E: GEOGRAPHICAL LISTING OF COLLEGES OF OSTEOPATHIC MEDICINE

APPENDIX F: STATE MEDICAL ASSOCIATIONS IN THE UNITED STATES

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INTRODUCTION

What can a community health center do to improve its ability to recruit and retain physicians? What compensation arrangements should be offered to a physician? What should physician employment contracts include and how should they be negotiated? And, what role should physicians play in the management and governance of a community health center?

This guidebook offers 40 tangible steps that you as administrators, governing board members, and staff of community health centers can take to attract and keep competent physicians. It brings together a wide body of information on physician recruitment and retention for easy reference. The actions and ideas presented can be adapted directly, built upon, or used as a springboard for innovative approaches to recruiting and retaining physicians in your community.

This guidebook is divided into four chapters and a set of appendices.

Chapter One presents strategies for recruiting physicians. It covers planning the recruitment effort and provides a comprehensive listing of physician resources.

Chapter Two looks at compensation arrangements commonly used at community health centers. It explores the relationship between compensation and retention. Also, fringe benefits and incentive plans are discussed.

In **Chapter Three**, the roles and responsibilities of the physician in the management and governance of health centers are examined.

Chapter Four outlines numerous physician contract elements and provides tips to help negotiate contracts. A sample physician employment contract is also included.

Appendices containing related information follow these four chapters.

While this guidebook was written for California's community health centers, it is designed to be of value to community and migrant health centers nationwide.

PHYSICIAN OUTLOOK

For years, community and migrant health centers in critically underserved areas have relied heavily on National Health Service Corps (NHSC) physicians to provide medical care. While the federal government currently maintains the NHSC, its future into the next decade is highly uncertain. This uncertainty comes a time of not only massive federal cutbacks but also forecasts of a physician surplus.

By 1990, the United States will have more physicians than it needs, according to the Graduate Medical Education National Advisory Committee (GMENAC).[1] A specialty and geographic maldistribution of physicians, however, will continue. There will be surpluses in the specialties of general surgery, cardiology, and obstetrics/gynecology, and shortages in emergency medicine and preventive medicine. The number of family and general practitioners is expected to match the populations in need.

The Bureau of Health Professions, Department of Health and Human Services, projects that between 1982 and 1994, the number of medically underserved counties will be cut almost in half due to the diffusion of excess physicians into these areas. This diffusion theory, however, is based on studies that excluded communities with populations of 2,500 or less--those communities most likely to experience physician shortage.[2]

Additionally, physicians tend to be attracted to areas with high physician populations, further compounding the physician maldistribution problem.

Therefore, the projected surplus does not necessarily mean that medically underserved communities will no longer have difficulty finding physicians.

Clearly, community and migrant health centers must continue mobilizing enough community resources, skills, and commitment to minimize their dependence on the federal government and to strengthen their abilities to recruit and retain physicians.

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[1] Summary of the Graduate Medical Education National Advisory Committee to the Secretary, Department of Health and Human Services. Department of Health and Human Services, 1980. (HRA-8-1651)

[2] Cordes, Sam M. and Eisele, Tura W., "Another Look at the Rand Studies on Physician Diffusion." Rural Primary Care, May/June 1984, Volume 6:3, as reported in "Focus on Rural Health," a publication of the Office of Rural Health, University of North Dakota, School of Medicine.

CHAPTER ONE

PHYSICIAN RECRUITMENT

Attracting highly skilled and suitable physicians is among the top priorities of many community and migrant health centers. The success of a recruitment campaign will depend on the active involvement of the heath center's administration, medical staff, board of directors, as well as the community.

Numerous research efforts have attempted to identify environmental, professional, personal, and economical factors that influence a physician's practice location decision. Studies reveal that physicians who are most likely to practice in a particular community are those who grew up, attended medical school, or completed an internship or residency program in the same or similar environment.

A review of the literature also reveals many reasons why physicians leave a practice location. Among these are professional isolation, an excessive on-call schedule, little opportunity professional growth and continuing education, insufficient income, social isolation for self and family, limited medical and professional resources, and unhappy spouse and family.

By recognizing the reasons for physician discontent in a practice, you can work to minimize their impacts at your health center and create a more engaging workplace, ensuring successful physician recruitment and retention.

SHAPING THE RECRUITMENT PLAN

Recruiting a physician can be a slow process but by planning ahead, the best results can be ensured. Whether the need for recruitment arises from an increase in demand for health services or an unexpected death of a physician, a health center that maintains an ongoing recruitment effort will be in a better position to attract qualified candidates. Often health centers will be vying for the same physicians as other health facilities, further emphasizing the importance of a well-organized and aggressive recruitment effort.

For the most part, few community health centers can afford or need full-time staff to work on recruitment. Instead, recruitment is meshed with a center's many other activities. Because of this, it is important that recruitment concerns are renewed regularly.

1. Assessing Community Health Needs

The first element in a recruitment effort is to clearly identify and analyze the surrounding community's health provider needs. Next, the type of health professional that can best meet those needs should be considered.

Primary care services can be provided by a family or general practitioner, internist, pediatrician, or obstetrician/gynecologist. Additionally, nurse practitioners and physician assistants can provide basic primary care services. Whether a family practitioner, other primary care physician specialist, or a nurse practitioner is recruited will depend, in part, on the health needs of your community.

BEFORE YOU RECRUIT

Important questions to be answered by community health centers **before** beginning a recruitment effort are:

- Where do people presently go for primary health care?
- What is the geographic area served?
- How many physicians serve the area? (by specialty and age)
- How many people live within the area?
- Is the population mobile?
- What is the current primary care physician/population ratio and does the ratio indicate a physician shortage?
- How many people not served now within the area would need the services of a physician?
- What are the present and future demands for health services?
- How do the health care services in the community compare with those of similar communities?
- What services does the health center offer? And for which services does the health center have particularly high demand?

- How does the community's population pay for medical care?

- What are trends in the indicators of health status? (birth rate, death rate, infant mortality rate, maternal mortality rate, and fertility rate)

- What is the community population's age, ethnic, educational, and economic background?

Additionally, the health center should consider the following:

- Annual patient encounters

- Annual patient encounters per physician

- Revenues generated

- Revenues generated per patient encounter

- Medical community's referral pattern.

2. Establishing a Recruitment Committee

Often, one of the first steps in developing a recruitment plan is to establish a committee. The committee can be used to identify health provider needs, select recruitment strategies and consider compensation arrangements. Committees can also screen applicants, conduct interviews and follow-up on potential candidates.

Broad-based community support is essential: the community must be willing to join in physician recruitment efforts. As community involvement strengthens, so will your abilities to recruit and retain physicians. Committee members should include the clinic's administrator, governing board members, the medical director, other health providers, and key members of the community.

To perform their tasks well, committee members should have the interest, talent and time, along with a good working knowledge of the community and the operations of the health center.

One person should be responsible for the committee's activities. Ideally, the chairperson will have the time, expertise, commitment, and community support to handle the job. Often, the administrator assumes this leadership role.

Organizing individuals to collectively make decisions affecting their community is not easy and not all health centers will want to have a recruitment committee. Instead, they may choose to delegate the responsibility for recruitment to the administrator or medical director. Others may want to contract part of the recruitment activities--the planning or implementation--to an outside recruiting agency. Still others may want to give complete responsibility for recruitment to a professional recruitment firm.

3. Developing a Job Description

Job descriptions should clearly define the kind of person who can fill a position and are often ideal in nature. The description should provide the position title, the primary reporting and working relationships, the duties, tasks and responsibilities of the position, and any unusual requirements (such as working two days a week in a satellite clinic 30 miles away).

The skills and knowledge needed, as well as ideal background, education, qualifications, certification, and experience required for the position should also be listed. Job descriptions should be reviewed periodically to determine if there has been any substantial change in responsibility.

4. Preparing a Community Profile

Promoting your community is a good way to ensure successful recruitment. You do not want a physician to overlook your community only because he or she knows nothing about it. Providing positive views of life and work in the community can draw the attention necessary for your recruitment efforts.

A one-page, printed brochure or a fact sheet with maps and other materials can be helpful in introducing a community. Besides covering the clinic and its services, the brochure or fact sheet can show what the community has to offer culturally, educationally, financially, and recreationally. Aspects that make the community attractive and special, and that may contribute to a physician's choice of practice location, should be highlighted. The local Chamber of Commerce is a good source for information and materials.

SPECIAL POINTS TO INCLUDE

Here are some suggestions for your brochure or fact sheet:

- Quote a clinic physician and/or key community member on why he or she likes the clinic, its services and/or the surrounding area.
- Describe the clinic--its size, service area and the services it offers. Describe the nearest hospital.
- Describe the geographic area of the community. Mention the nearest large city, neighboring towns, and points of interest.
- List special community events, discuss the economic base, school systems, and recreational sites. Social and religious organizations can also be listed.
- Provide information on year-round weather.

Some communities have put together loose-leaf binders of photographs showing all aspects of community life, including recreational sites, the clinic, local hospital, schools, and business and residential areas.

A one-page announcement on the practice opportunity, suitable for posting on a bulletin board, can be sent to residency programs, medical schools, local and state medical associations, and health planning agencies.

Remember, the community profile should only be an introduction. Try to keep it brief. Also, be sure that it provides an honest presentation.

5. Paying for your Recruitment Efforts

Physician recruitment is costly, both in dollars and time. Long distance telephone calls, recruitment and informational brochures, advertising, postage, and travel expenses to the community by applicants all require money. Another typical recruitment expense is the payment of reasonable moving expenses.

Community-wide fundraisers--garage sales, cake sales, raffles, and benefit sports events and dinners--can be held to raise money, although it is wise not to depend on income from these activities. Perhaps more important than supplementing a clinic's recruitment budget, fundraisers create community interest and awareness in and support for the health center's activities.

6. Identifying Recruitment Sources

Numerous sources are available to recruit physicians and are listed here. Each should be carefully considered for application in your community and to be sure that the particular recruitment effort is affordable. It is a good idea not to limit yourself to only one source, rather several avenues should be pursued.

The following are recruitment sources to consider:

(1) **Residency programs**. A number of residency programs focus on family practice and primary care. Most residencies are for three to five years. In California, physicians have to be licensed after completing their second year of postgraduate training.

Physicians are ready to begin work each year in July, when residency programs are completed. It is not uncommon for these new physicians to begin seeking practice opportunities in their second year of residency. (Some physicians "moonlight" while they do their residency.) Many have a position lined up at least six months before their residency ends.

A one-page announcement on your practice opportunity, which is suitable for posting on a bulletin board, can be sent to the directors of the various residency programs.

Few residency programs allow on-site recruitment. If you are considering a recruitment visit, it is recommended that you contact the program beforehand to see if visits are allowed and to arrange for an appointment.

In addition, health centers offer excellent training for physicians in family practice residencies. Residents are exposed to practice in a clinic setting while providing the clinic with medical assistance. Moreover, the residents that rotate through your clinic may return after completing their training for permanent employment. Therefore, establishing good relationships with residency programs can help your physician recruitment efforts.

For more information on how your health center can be a site for family practice residency training, contact the directors of residency programs nearby. (See Appendix A for a list of family practice residency programs in California.)

(2) **State Medical Association**. The California Medical Association (CMA) is an excellent source for physician recruitment. It publishes the **Physician Placement Bulletin** of physician opportunities and provides lists of available physicians by specialty. The lists are updated every two to three months and are organized by specialty: family practitioner/general practitioner, obstetrician/gynecologist, pediatrician, internist and sub-specialty, and primary care (not necessarily a duplication of the other categories).

For more information on advertising in the bulletin or obtaining lists of available physicians, contact Margie Ross, Coordinator, Physician Placement Service, California Medical Association, 44 Gough Street, San Francisco, CA 94103-1233, (415) 863-5522.

(3) Advertising. Advertising can be an effective recruitment strategy, although expensive.

Professional journals. Since family practitioners provide most of the medical care at health centers, job openings should be placed in specialty publications such as the **American Family Physician** and the **Journal of Family Practice.**

Some health centers may find it helpful to list their openings in other professional journals or newsletters that are circulated nationally. Common choices are the **Journal of the American Medical Association, New England Journal of Medicine,** and **American Journal of Public Health.**

The ad should tell the reader a little about the clinic, summarize the major responsibilities and duties of the position, indicate the experience required, refer to any compensation, amenities or opportunities, and list a contact name, address or telephone number, and a final filing date.

Keep in mind that there can be a lag time of up to eight weeks from the time you submit an ad to when it appears in print. In addition, journal advertisements can be expensive.

The rewards of advertising in a journal are best if the ad runs consistently from month to month. Also, you may have more success if you advertise your position opportunity in east coast publications in winter when the area is blanketed in snow, to lure physicians to the west coast's milder climate.

(See Appendix C for a listing of public health and medical journals that offer exposure to primary care physicians.)

Newspaper ads. Newspapers of large cities are helpful for spreading the word nationally. The **New York Times, Wall Street Journal**, even the **Los Angeles Times, San Francisco Chronicle**, or **Washington Post**, offer wide exposure.

Additionally, do not overlook the local newspapers in your own community. Not only can you advertise directly for a physician, but you can ask readers to let friends, relatives, or local residents who are enrolled in medical schools or residency programs know about the clinic's practice opportunities.

(4) Publicity. Public relations is different from advertising. Instead of paying the media, the media is used for advertising at no cost. If the material is newsworthy and well-presented, the local newspaper, and radio and television stations should be willing to carry it as a news item, public service spot, editorial comment, or a topic on a talk show.

The most common way to publicize is with a press release. This is usually one to four pages, double-spaced and can include photos. It can be sent to newspapers, radio stations, newsletters, magazines, and television stations. Of course, whether or not the story is printed or aired, and favorable will depend on the writer's or editor's judgment. These drawbacks can be minimized by getting to know the editors, writers, broadcasters, or general managers.

FIVE NEWS IDEAS

Press releases can be used to:

- Announce the opening of the health center or satellite site, or let the community know about its expansion plans.

- Profile a member of the health center's health provider staff or employee of the month.
- Feature community members that have contributed to the health center by volunteering as board members or in other areas.
- Cover events such as fundraisers and open houses.
- Do a story on the difficulties of physician recruitment or the community's need for more health providers.
- Present health education or discuss a health problem that may be prevalent in the community.

In any press release, mention can be made that the health center has or will have a physician opening. If the center has no immediate need for a physician, publicity is a good way to make the community aware of the health center and its role in providing high quality and affordable health care, hopefully making it easier to rally community support and attract physician recruits later when needed.

(5) Local medical society. Many local medical societies assist in matching available physicians with manpower-short health facilities. Several societies publish bulletins periodically that list positions available and positions needed. (See Appendix D for a list of local medical societies in California. Those societies that publish monthly bulletins that carry classified ads are noted.)

(6) Recruitment/placement services. A number of placement bureaus and consulting firms specialize in recruiting physicians. If you decide to use a placement bureau, shop around. Find out how much the fees are and what services are offered. Be sure to carefully check the agency's references before contracting for services. Also, find out how many physicians they have placed in similar health centers, how long the placement took, and if the physicians are still there. Most importantly, make sure you understand any contracts. It is

a good idea to seek legal advice before signing on the dotted line.

(7) The American Medical Association. The American Medical Association (AMA) also has a placement service. Bimonthly, the AMA's Physician's Placement Service publishes the **Physician Placement Register**, which lists brief information on hundreds of physicians, and the **Opportunity Placement Register**, which contains a brief synopsis of available practice openings. The **Opportunity Placement Register** is sent to each physician listed in the **Physician Placement Register.**

A listing in the **Opportunity Placement Register** for three consecutive issues (six months) and a subscription to the **Physician Placement Register** costs about $195 for community health centers.

For more information, contact the Physician's Placement Service, American Medical Association, 535 North Dearborn Street, P.O. Box 10012, Chicago, Illinois 60610, (312) 645-4712.

(8) Personal contacts. Physicians employed by a health center are the best source for recruiting new physicians. When a valued employee recommends a physician, the administrator and board can be assured that they have received the name of a qualified prospect. Administrators and physicians, through their associations with other clinic managers and staff, can also spread the word about available practice opportunities at medical conferences and meetings.

(9) National Health Service Corps (NHSC). The NHSC places health professionals in areas with critical shortages of health providers. Often, it provides a listing of NHSC physicians who will soon complete their obligation and are seeking employment elsewhere. In addition, the NHSC keeps a list of physicians who are interested in working in medically underserved areas. For more information, contact the NHSC, Department of Health and Human Services, Public Health Service, Region IX, 50 United Nations Plaza, San Francisco, California 94102, (415) 556-3690.

(10) Preceptorships. Community service or clinical preceptorships offer medical students firsthand exposure to community-based health care while providing health centers with capable health provider assistance. Providing learning experiences for medical students is also an excellent way for health centers to establish valuable linkages with medical schools for future phy-

sician recruitment. Once a health center has a project planned, medical schools can be contacted directly. (See Appendix B for a listing of medical schools.)

Medical student associations and word-of-mouth can also be useful in recruiting students for preceptorships. Working relationships with their medical schools can be established later.

Currently, the American Medical Student Association is administering a two-year program to place 50 students each year in community and migrant health centers to conduct projects in health promotion and disease prevention. This program began in February 1985. For more information, contact the HPDP Project, AMSA Foundation, 1910 Association Drive, Reston, Virginia 22091, (703) 620-6600.

(11) Osteopathic Physicians. Osteopathic physicians (DOs) are medical physicians with the same training as allopathic physicians (MDs). Both may be licensed in all fifty states to practice medicine and surgery.

Osteopathic medical education emphasizes osteopathy; the science that recognizes the body's muscularskeletal system's affect on overall health. In addition, osteopathic education focuses on general practice while most allopathic (MD) education programs are primarily directed toward specialty training, one of which is general practice.

Over 75% of this country's osteopathic physicians are in family practice, many in small rural communities. California has some 550 licensed osteopathic physicians.

For a directory of osteopathic physicians licensed by the California Board of Osteopathic Examiners, contact the state board at 921 11th Street, Suite 1201, Sacramento, CA 95814, (916) 322-4306. (See Appendix E for a listing of osteopathic medical colleges accredited by the American Osteopathic Association and approved by the California Board of Osteopathic Examiners.)

CHOOSING THE RIGHT PHYSICIAN

Any physician will not do; the expectations a physician has for the practice must match the community's needs. Therefore, it is important for a health center to target its recruitment efforts so that the best match can be made.

7. Making a Favorable First Impression

Once candidates have been identified, a friendly and informative introductory letter should be sent to each one. The letter should include information on the health center, the position and the community. This letter may be the candidate's first exposure to your community and the position opening so it should make a favorable impression.

Similarly, it is unlikely that your position is the only one being considered by a candidate. A note saying that a member of the recruiting committee will be contacting the candidate soon to determine his or her interest in the position makes the letter more personal. Of course, it is important to make sure the candidate is indeed called.

8. Screening the Candidates

Normally, a telephone call is all that is needed to determine if a candidate is interested in the position and if he or she is qualified, as well as suitable for the practice opportunity. By finding this out **before** you invite a candidate to your community, you will save valuable time and dollars.

TIPS FOR CHECKING REFERENCES

When checking references, it is important to:

- Ask for written and verbal references from those individuals listed by physician.
- Check references other than those provided by the candidate.
- Contact the medical director or administrator of the candidate's previous place of employment.
- Contact the chief of staff or administrator of the hospital where the candidate has had staff privileges.
- Contact the president of the local medical society.
- Have a member of the medical staff make telephone calls to other physicians for reference checks, if possible.

When checking references for physicians completing residency programs:

- Use references given by the candidate.
- Contact the director of the residency program.
- Ask the residency program director for the names of at least one faculty person and one attending physician who were not submitted by the applicant as a reference.

9. Ensuring a Successful Site Visit and Interview

Once the recruitment committee or administrator has identified interested, qualified, and compatible physicians and references and credentials have been checked, the next step is usually to invite the candidates for a visit. Many health centers also invite the physician's spouse and family. Each clinic must decide whether or not it will reimburse candidates for all or only part of the travel expenses.

Before the candidate arrives, an itinerary for the visit should be developed. Besides the job interview, much of the itinerary will include activities specifically related to the physician's spouse and family. Before the visit, find out, the areas of the most interest to the physician and family so that the site visit can be tailored to their needs.

Careful attention should be made so that physician will get the best view of the community. Factors that impressed others to move to the community and points that make the area unique should be emphasized. Activities should be planned to vigorously yet earnestly recruit the spouse and other family members. Key community leaders and medical staff can be briefed beforehand about the candidate and his or her family so that they can address each by name.

ORGANIZING THE VISIT

Typically, a candidate's visit should include:

- Interviews with the administrator and recruiting committee members during which financial and practice considerations can be discussed.
- Interviews with medical staff. The staff can emphasize the clinic's positive qualities,

describe support staff and other medical matters.

- Hospital tour to meet the hospital administrator and key medical staff.

- Social activities. The hospitality of local residents can make a difference on the outcome of a candidate's visit. A tour of the town, major medical facilities, and recreation areas is a good introduction. Medical and community members can meet the physician and his or her family at social events tailored to their interests. The goal is to make the physician and family feel positive about relocating to the community. (A small informal dinner at the administrator's or a physician's home is usually a more effective recruitment strategy than a large, formal dinner at a restaurant.)

- Time to relax and explore. Be sure to leave enough free time for the physician and family to tour the community on their own and discuss the position, the community, and possible relocation among themselves. If the candidate did not drive his or her car to the interview, consider lending a car so that he or she and family can attend matters of special interest.

Be prepared to describe some of the negative aspects of the position and the community. It is best to be honest during the initial recruiting process than to exaggerate or mislead, only to lose the physician once he or she is on board.

10. Attending to Spouse's and Family's Needs

Although recruiting a physician is the primary objective of any recruitment effort, the physician's spouse and family must also be recruited. The spouse and family play critical roles in the physician's decision to work in a community, and an even greater role in the decision to remain there. Even if the physician finds the practice suitable, he or she is unlikely to accept the position if the community cannot meet the needs of the family.

Establish a relationship with the spouse during the initial telephone contacts before the visit, if possible. The professional and personal needs of the spouse can then be better addressed during the visit. Information on nearby colleges and universities, employment opportunities, housing, and recreational and community activities can be forwarded to the spouse.

Copies of the local paper can be sent to the candidate and family for another introduction to the community. A good map can also be included. Also, the physician's children may be interested in looking at school yearbooks.

11. Following-up After the Visit

If you want to hire a physician, an offer can be made before he or she leaves the community. A letter can then be sent to the physician following the visit documenting what was discussed. The administrator or a board member should also telephone to confirm the clinic's interest in hiring the physician and to get a commitment from the physician. Once the physician makes a commitment, a signed agreement should be obtained.

If the physician will be relocating, someone should be responsible for assisting the physician and his or her family in relocating. Living accommodations, spouse's and children's interests, school registration, religious and social affiliations, banking concerns, as well with clinic matters, all may need attention.

12. Bringing the New Physician on Board

By keeping in touch, the recruitment committee can help to ensure that the physician and his or her family have a smooth transition and a warm welcome in the community. News releases and announcements to the medical community and local media can be prepared for a more formal, widespread community introduction.

It is a good idea for the administrator and/or a board member to periodically visit with the physician and his or her family for about one year following employment to make sure things are going well. People do things differently in other places. Culture shock is not uncommon for those who move from north to south or east to west. Having someone to help the newcomers adjust to the community, as well as the demands of the position, is an essential ingredient for successful recruitment. It is important that the new physician be satisfied, not only because he or she is needed, but also because the person is a good referral source if another physician is needed.

FOR MORE INFORMATION

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CHAPTER TWO

PHYSICIAN COMPENSATION

Establishing a fair and competitive compensation arrangement for physicians is essential to the continued growth and success of a community health center. Increasing local competition by organized medical groups such as health maintenance organizations, proprietary hospital corporations, and large group practice associations puts pressure on health centers to offer both financial and professional incentives that will entice physicians to practice in community health center environments.

Compensation arrangements should attract and retain competent health providers, provide incentives for productivity and professional development, and be consistent with federal and state laws. Moreover, they should be responsive to changes and easy to administer. Obviously, compensation levels should not be so excessive that they strain the health center's economic viability.

Motivating physicians to practice in unpopular urban and rural areas requires diligent and ongoing assessment of the local environment, the local health care competition, and the needs and goals of both the physician and the health center.

13. Assessing the Health Center's Needs and Goals

The needs and goals of the health center and its expectations of provider staff must be assessed when developing a physician compensation plan.

Physicians should be compensated based on their training and any additional skills that might benefit the health center. However, they should be compensated for only those skills required to meet the needs and goals of the health center.

EVALUATING YOUR PHYSICIAN NEEDS

Here are some questions to help determine what skills a physician needs for your practice.

1. Does the physician need to speak another language?

2. Is prior urban or rural clinical experience required?

3. Does this position require the physician to be board certified or eligible?

4. Is any special education required of a physician in this position, other than residency program or internship?

5. Is the physician expected to see more patients than usual for this specialty?

6. Is the physician's prior experience or employment important?

7. Are staff privileges at a local hospital required of the physician?

8. Is the physician required to fulfill any continuing education requirements in addition to those required for state licensure?

9. Will the physician be required to work more than a 40-hour work week?

10. Will the physician be required to assume any management or administrative responsibilities?

14. Assessing the Physician's Needs and Goals

The establishment of a physician compensation plan should also include a thorough assessment of the physician's personal and professional goals. This will assure a satisfactory balance of direct compensation, benefits, and/or financial incentives.

The physician's professional needs to consider are income, benefits, time-off, academic affiliations, administrative and management interest, hospital practice, and research projects.

Information about the physician's personal life may also influence the compensation package offered. This may include age, marital status, family commitments, hobbies, religious preferences, and occupation and activities of the spouse.

For example, a family practitioner, on completing his residency, relocates to your community with his wife and three children, and is seeking a job opportunity. Having recently completed his residency, the physician wants to begin paying off some of his educational debts. Additionally, he wants to secure his family's future with a good retirement package and health insurance benefits. New to the business of medicine, the physician may be very productive and could be paid on salary plus a percent of gross revenues, providing an incentive to be productive.

On the other hand, the physician may want more security while he is still testing his new skills and may be more easily recruited on salary, with an incentive plan to start after the first year.

15. Analyzing the Local Market

The local environment will act as the primary foundation for establishing your physician compensation plan. An analysis of compensation packages at other medical clinics, group practices, and hospitals in the surrounding community is essential in establishing an equitable compensation plan for the physician at your health center. When analyzing the local market, the following information should be gathered:

Number of Physicians by Specialty. The number of physicians in a community may have a significant impact on the retention of physicians at a health center. If the local market is overpopulated with family practice physicians, it may be wise to recruit physicians locally who are already acclimated to the particular environment. If there are few family practitioners, you may need to develop a more enticing compensation package to attract needed physicians.

This information can be obtained from the regional health systems agency, chamber of commerce, California Medical Association, American Medical Association, county medical society, Office of Statewide Health Planning and Development--Health Manpower Division, and the U.S. Bureau of Labor and Statistics.

Compensation Offered by Local Health Facilities. Many medical institutions are willing to share information on their compensation plans. Therefore, establishing a good rapport with local clinic and hospital administrators can help you develop and assess your compensation package. In addition, compensation plans in the local community should be reviewed annually so that you can adjust your compensation plan accordingly.

Local hospitals, clinics, group practices, the county medical society, and the American Medical Association may be able to provide some compensation data.

Demographics A review of the characteristics of the local population should be conducted before establishing the physician compensation package. Projected population trends, changes in industry, population data by sex, age, and family size should be examined. Health status indicators including birth and death rates, infant mortality rates, and fertility rates should also be reviewed. The number of physician visits per person by age can also be helpful determining the number of needed physicians.

Sources for obtaining demographic information include the regional health systems agency, the state Department of Health Services, county planning department, local hospitals and clinics, county medical society, California Medical Association, and the U.S. Bureau of Labor and Statistics.

16. Selecting Compensation Arrangements

Flexibility is the key to offering a compensation plan that is not only competitive with the local market and protects the financial interest and operating budget of the health center but is also tailored to meet the physician's needs and provide an incentive for productivity. Moreover, a health center's compensation plan should reflect its willingness to attract and retain qualified practices.

The compensation package can be as simple as a guaranteed yearly salary or as complex as a base salary, benefits, incentives, and bonuses. Each compensation arrangement has tax consequences that can influence its respective advantages for the physician. Compensation arrangements are never permanent and should be periodically modified to protect the interest of all parties.

Grants or contracts may affect the use of grant or contract funds for certain compensation plans. If the contract or grant does not specifically allocate a fixed amount of money to a compensation plan, then the money serves as a foundation for the center's budget, allowing management personnel to allocate funds towards the compensation plan. Of course, anticipated revenues from other sources may offset the amount of money set aside for compensation under the contract or grant.

Percentage Arrangements

Under a percentage arrangement, the physician receives a fixed, predetermined percent of either the health center's net or gross income. With a percentage arrangement, each physician can equally share the income of the center or, in a one-physician center, a fixed percentage of the revenues.

An advantage of the percentage arrangement is that it is easy to describe and administer. However, it may not allow for recognizing individual physician differences in economic terms; for example, one physician may see more patients than the other physicians.

Additionally, setting up a percentage arrangement can be time-consuming and may involve extensive negotiations with the physician. The percentage, whether net or gross income is the base, and how net income is defined must be considered.

EXAMPLE OF A PERCENTAGE ARRANGEMENT

Gross revenue from patient care	$4,500/month
Expenses	$1,500/month
Net revenue	$3,000/month

Under this percentage arrangement, the physician receives 75% of net revenue: 75% of $3,000 is $2,250. The 75% figure is arbitrary and should be developed based on your analysis of the local market.

Straight Salary

A salary is a fixed amount of money paid to the physician either weekly or biweekly. It is simple to administer and may be used in combination with other plans. Although the straight salary method of compensation controls operating costs, it alone provides no incentive for productivity. Most importantly, the salary should be adjusted regularly to reflect economic conditions, the costs of providing services, and local competition.

Fee-for-Service

The fee-for-service compensation plan is based on a fee schedule for services provided. Again, this method can be incorporated with other plans.

The fee-for-service compensation plan provides the physician with an incentive for generating new business and controlling overhead. It may, however, cause rapid physician turnover where operating costs are not adequately controlled by management.

The fee-for-service compensation arrangement can be combined with other compensation models. The health center could provide a physician with a minimum guaranteed salary to meet living expenses should the physician not generate enough money under the fee-for-service arrangement during the initial years of practice. The physician would also pick up all or part of the clinic's overhead. The key is to keep the salary guarantee high enough to attract the physician but low enough to provide the physician with the incentive to improve productivity.

For example, the physician receives a minimum first year net (after expenses) salary guarantee of $40,000 and pays 30% of the overhead attributed to expenses for his or her part of the practice. If the physician generates $55,000 in gross receipts and the expenses attributed to his or her portion of the practice are $28,000, then this would leave the physician with a net salary of $37,000. The clinic would then have to make up the additional $3,000 towards the salary guarantee of $40,000. The guaranteed salary, of course, can be adjusted annually or monthly. The center may also elect to provide the physician with certain nontaxed benefits, as a trade off for paying more of the overhead or taking a lower salary guarantee.

BEFORE OFFERING A COMPENSATION PLAN...

These are some important questions that should be answered before developing a compensation arrangement--

1. What have been the average gross revenues generated by other physicians in the same specialty in the health center?

   This may provide an indication of how to compensate the physician.

2. Is the physician responsible for managing his or her support staff?

   The physician may want to maintain more control in this area if he or she will be covering part of the cost.

3. How much control does health center management have over expenditures?

   If the physician is given complete control over some center expenses, with little constraints, he or she may choose to spend more money, increasing the center's liability towards any salary guarantee.

4. How are physicians compensated now? Are they all compensated under the same arrangement?

   This may have a big impact on the health center's ability to offer one plan over another.

5. What impact will a particular compensation arrangement have on the health center's information and data management system?

   Each compensation plan has its own accounting requirements.

6. Which compensation model best matches the health center's and physician's understanding of the physician's overall authority, responsibility, and accountability?

7. What impact will the compensation plan have on the health center's tax status?

8. What compensation arrangement would best serve the needs of the patients and the goals of the health center?

Lease Arrangement

The leasing of a facility and equipment to one or more physicians is another compensation method, although seldom used in community health centers. It offers the advantage of providing essential services to the community while enabling the health center to better control its operating overhead. The lease arrangement method is usually combined with other financial incentives. This may involve paying the physician or group of physicians a percentage of net revenue, after expenses. These expenses would include any leasing fees.

If, for example, a physician leases a clinic for $1,200 per month and equipment for $200 per month and the clinic generates $3,500 per month in gross revenues, the physician would receive $2,100, (gross amount less $1,400 for building and equipment lease). These figures are only rough examples and do not apply to any specific situation. The clinic may include other

incidental expenses such as utilities, staff benefits, staff salaries, or other operating costs.

The lease arrangement provides an incentive for the physician to increase productivity and encourages the implementation of cost controls. It also gives the physician complete authority, responsibility, and accountability for medical activities. A disadvantage is that administrative personnel may experience difficulties in controlling the allocation of the physician's time. This may be especially true of physicians who practice at multiple locations, since some providers tend to support those facilities that provide the greatest source of revenue.

The lease arrangement method of providing health care services must be monitored closely and should involve a contractual agreement outlining items such as fees, allocation of physician time, budgetary guidelines, and specific clinical expectations. Physician employment contracts may be difficult to prepare for lease arrangements; therefore, legal assistance is strongly advised in preparing these contracts.

Combination Arrangements

Most often, compensation arrangements are combined. One possible option is to provide the physician with a fixed salary slightly below market rate and offer a percentage of net revenues, after expenses.

For example, a physician joins a health center and expects to make about $65,000 per year. Management may choose to offer him or her a fixed salary of $55,000 per year, in addition to a percentage of the net revenues, after expenses.

PHYSICIAN COMPENSATION CHECKLIST FOR HEALTH CENTERS

The major components in developing a physician compensation plan are highlighted below:

1. Health center goals

    - Revenues
    - Patient volume
    - Market visibility
    - Creation of new clinic programs
    - Research (study programs)
    - Containing costs

2. Physician goals

    - Income
    - Benefits
    - Time-off
    - Family commitments

- Academic affiliations
- Administrative interest
- Research projects
- Off-hour patient visits

3. Local competition

   - Hospitals
   - Private practitioners
   - Group practices

4. Area demographics

   - General population
   - Physician population
   - Projected population shifts
   - Patient types/reimbursement sources

17. Providing Financial Incentives

A compensation plan should induce a physician to be a productive and contributing member of the health center. Some health centers offer financial incentives as part of their overall compensation packages. With incentives, the more a physician accomplishes or produces, the more pay or other benefits he or she receives.

The incentive can be based on a variety of factors, including one or more of the following:

- Total revenue
- Patient volume
- Hours worked
- Gross revenue
- Patient types
- Hospital revenue
- Off-hour patient consultations

Regardless of the factor on which the incentive is based, no incentive should be contrary to quality patient care.

Generally, financial incentives are part of a compensation arrangement. Two sample situations are presented here:

Incentive plan based on straight salary plus health center productivity. A physician recently completed a residency in internal medicine and is looking for a position with a community health center. He also plans to do a large amount of hospital work and conduct research. He is single.

Compensation: To provide an incentive for productivity, the physician can be given all or a percentage of his hospital patient billings (net collections). This coincides with the physician's desire to do hospital work and rewards him for doing so.

Because the physician will be receiving a fair amount of revenue from his hospital billings, the health center administration may be able to bargain with his base compensation and benefits. A straight salary is probably the best compensation method to offer this physician. Benefits can be tailored to meet his personal and professional needs.

Incentive plan based on a percentage salary arrangement. A family practitioner with ten years of experience in an urban environment has applied for a position at a health center. She is accustomed to working long hours and seeing 40 to 50 patients per day. Much of her work has been caring for the indigent patient population.

Compensation: The clinic has several options. First, the physician could be offered a percentage of the total cash receipts for all clinic and hospital patients, less overhead costs. Alternatively, she could assume the responsibility for overhead, with a greater share of the cash receipts.

For example, the physician receives 60% of cash receipts for all hospital and clinic patients. She is also responsible for all overhead cost.

Average Monthly Clinic Cash Receipts	$15,000
" " " " Hospital " " "	$12,000
Total Cash Receipts	$27,000
Overhead Cost	$10,000
Physician receives 60% of $27,000	$16,200
Less $10,000 Overhead Cost	$10,000
Net Monthly Revenue to Physician	$ 6,200

In this example, the physician is responsible for all of the overhead costs. If the health center decides to pick up part of the expenses, it would reduce proportionately her percentage of cash receipts. The remaining 40% of gross billings ($10,800) would give the health center some cash reserves to cover other or unanticipated costs, which are not included as part of the physician's contract.

Or, the health center could offer a lower percentage of cash receipts (40%) and be responsible for all or part of the overhead costs. The health center would then be at a greater risk and must carefully control costs to operate with a positive cash flow.

18. Offering Fringe Benefits

Fringe benefits are often a significant portion of a compensation plan. A well thought-out benefit package will aid in recruiting and retaining physicians. Again, the physician's personal and professional interests may dictate what benefits are offered. Benefits are not taxable.

Some medical organizations and other businesses offer a flexible or "cafeteria-style" benefits plan, which allows the individual employee to select certain benefits instead of additional cash income. This system allows the organization to control costs while providing employees with the flexibility of choosing benefits that meet their particular needs. A disadvantage for the employee to this flexible plan is that the cash income received in lieu of benefits is taxable.

Implementing a flexible benefits program can be complex and time-consuming. Such a benefits program should not be offered without competent legal and acturarial advice to make sure the program is consistent with current federal and state tax laws.

The level of benefits offered becomes a critical issue when the private clinic across the street or the hospital in the same community offers a more desirable compensation package. The importance of conducting a local market survey before implementing a compensation program cannot be overstated.

CHECKLIST OF BENEFITS

Here is a list of benefits other than cash compensation that can be offered:

* malpractice insurance
* health insurance
* dental insurance
* life insurance
* disability insurance
* survivors benefits

- moving expenses
- retirement or pension plan
- tax deferred annuity
- professional licensing fees
- professional society dues
- textbooks, reference manuals, journals
- payment for jury duty
- military leave
- bereavement leave
- tuition, travel, per diem for continuing medical education
- registration, travel, per diem for professional meetings
- sabbatical leave
- leave without pay
- sick leave
- holidays
- vacation time
- maternity/paternity leave
- financial and release time support for research
- auto expenses
- leave for volunteer and community work
- deferred compensation
- profit sharing
- compensatory time
- loans

Insurance Programs

Health Insurance Health insurance is a standard benefit for all personnel. The level of benefits covered under a major medical policy depends on the corporate status of the business, as well as the number of employees covered under the policy. Umbrella policies that cover all employees are generally less costly than individual policies.

Life Insurance Many health centers offer life insurance. Several factors will influence whether a physician wants life insurance and if so, which type.

If the physician is married, he or she may want a life insurance policy to protect his or her family's future. On the other hand, to the single physician, a life insurance policy may be of little value.

Two policies commonly offered are term insurance and whole life. The cost of either whole or term insurance will be more expensive for individual policies than for a large medical group.

Term Insurance - Normally, this is the best buy for a young physician seeking maximum protection. Term insurance allows the physician to insure him- or herself just as he or she would for a car--for a given amount of value over a given amount of time. If there is no "loss," there is no benefit. The term period is often one to five years and the policy can be renewed at the end of the term but at a higher premium, since the age of the insured will put him or her at a higher risk of loss. A principal drawback to term insurance is that it must be renewed often over the years. At each renewal, the physician is older, increasing the premium, as well as the risk of not being able to renew the insurance coverage.

Whole Life - Whole life insurance is another option. This is also referred to as "ordinary life" or "straight life insurance." A whole life policy is similar to an endowment except that it becomes paid up at the age of 100, so the physician pays premiums as long as he or she lives. Part of the premiums are contributed to a savings account at a very slow rate; this is referred to as the cash value.

Disability Insurance Disability benefits are common in today's marketplace. This insurance provides an employee with income for up to 39 weeks after the date of disability. If an employee receives disability compensation, all disability benefits paid over $100 per week must be reported as taxable income.

Every health center should be expected to pay a physician when he or she is unable to work. Typically, professional corporations continue salary for a period of three to six months. However, most subtract from their payments any income from disability insurance (SDI) for which the employer has paid premiums.

If another physician is found to temporarily cover for a disabled physician, the salary paid to the substitute should be deducted from the amount the employer pays the disabled physician.

A partially disabled physician may need his or her paycheck even more than a completely disabled physician because disability insurance payments may cease when a physician can return to work--even part time. Unless the health center cannot use a physician who can carry only a partial workload, it should provide for partial disability payments.

A partially disabled physician may present problems for the health center if "partial disability" is not defined in the physician's contract. It is wise to include in the physician's contract that any disagreements over whether a physician is fully or partially disabled will be decided by arbitration.

An additional way to avoid confusion over disability is to require a two-month waiting period before the partially disabled physician can collect any pay, unless the impairment is part of the convalescence from a complete disability. The partially disabled physician should receive prorated income in proportion to the fraction of the normal workload he or she carries.

A contingency clause, spelling out the disability procedures, should be incorporated into the physician's contract. Two essential items to be included in the contract are how long a physician must have been back to work after being disabled in order to receive full benefits if he or she is disabled again, and a total number of disability payments the health center will make during any given period.

Professional Liability Malpractice insurance is essential for each physician and can be a major expense for some specialties. Today, malpractice insurance is more a necessity than a benefit.

Before offering malpractice coverage, become familiar with the various types of malpractice insurance available and conduct a thorough analysis of state regulations regarding malpractice coverage. This information can be obtained from the county medical societies and the California Medical Association.

Deferred Compensation and Retirement Plans

Present laws make few distinctions between retirement plans set up by unincorporated physicians (usually called Keogh plans) and those corporations. Nearly all retirement plans fit into one of the following three categories:

- Defined-Contribution Plan (Profit-Sharing)
- Money-Purchase Plan
- Defined-Benefit Plan

Defined-Contribution or Profit-Sharing Plan. This retirement plan is a method of deferring taxable income. It allows an individual to contribute an amount based on a percent of gross salary. The percent of gross salary used to determine profit salary deductions may vary from year-to-year, and may be based on the productivity of the health center. It is important to keep in mind that there are limitations on the amount that can be contributed to a profit-sharing plan in any given tax year.

A profit-sharing plan is simple and requires no complicated formulas. A physician or health center may choose to set up a profit-sharing plan alone and have complete control over the amount contributed.

Forfeitures or money left behind by employees when they leave must be subtracted from contributions to a profit-sharing plan if they would otherwise push the annual additions over the 15% maximum.

Money-Purchase Plan. This type of retirement plan allows a contribution of up to 25% of salary or $30,000, whichever is less. The percentage is fixed in advance, so the amount contributed remains the same, regardless of practice revenues.

The money-purchase plan can be combined with a profit-sharing plan, allowing more flexibility in administering the plan and enabling the physician to contribute the tax-deductible maximum.

For example, a physician makes $80,000 in gross income and chooses to contribute to both a profit-sharing and money-purchase plan. The physician has a money-purchase plan that calls for a contribution of 10%, therefore, $8,000 goes into the retirement plan annually. If the physician also participates in a profit-sharing plan, he or she can contribute another 15%, or $12,000. The annual ceiling on total tax-deductible contributions to a money-purchase and profit-sharing plan is 25% of salary but not more than $30,000. This dollar limit is adjusted annually to keep up with the pace of inflation.

Defined Benefit Plans. These retirement plans require the individual to predetermine his or her annual contribution. The contribution can be up to 100% of salary, based on a three-year average but not more than $90,000 a year, if retirement age is 62 to 65. The limit is lower if retirement is to begin before the age of 62 and higher if later than 65. The amount contributed is based on the benefit goal and is not directly affected by what is earned from year-to-year. Generally, a defined-benefit plan will allow the individual to contribute more than would a defined-contribution plan.

Two specific defined-benefit plans are the **target-benefit** plan and the **fixed-benefit** plan. In the target-benefit arrangement, any investment earning of the retirement fund above or below the actuary's projections will fatten or decrease the projected retirement benefit. Because the actuary usually assumes that the earnings will be at a modest level, typically 6 to 7%, the plan earnings can be greater than for what the plan originally called. However, contributions to a target-benefit plan are subject to the same yearly $30,000 or 25% percent limit as are defined-contribution plans.

In the second type, the fixed-benefit plan, any plan earnings over the projected amount reduce the contributions. But if plan earnings fall short, the contributions must be increased to make up the difference so that the retirement benefit will come out as projected. Thus, a physician who can afford to put away more than the defined-contribution plan allows may get bigger tax deductions with this type of defined-benefit plan.

As an example, a 50-year-old physician with an annual net income of $80,000 can only put $16,000 into the defined-benefit plan. But if he or she wants to contribute $24,000 each year, leaving a "salary" of $56,000, he or she can do that with a defined-benefit plan. The physician would then end up with roughly $34,000. By taking an even lower salary, the physician could further increase his or her annual tax-deductible contribution. Keep in mind that the benefit for all eligible employees would have to be the same percent of salary as for the physician, and that the contributions the physician would make will be correspondingly larger.

Defined-benefit plans are not suitable for every physician. The younger the physician, the more time there is to build the fund so the less the physician is allowed to set aside each year. If the physician is 35 instead of 50, he or she could probably contribute more to a conventional defined-contribution plan.

Most all types of retirement plans are affected by the Employee Retirement Income Security Act of 1974. This law and the elements affecting the establishment of retirement plans change frequently and heed should be taken when providing retirement plans. It is strongly recommended that a tax accountant and/or attorney be consulted periodically.

Bonuses

Bonuses based on productivity and revenues of the health center can be offered at the discretion of the health center's administration and may be based on a predetermined contractual arrangement. Such an arrangement should be in writing and detail specific requirements to be met as they relate to the bonus plan. However, nonprofit corporations cannot legally distribute profits for any individual's gain. Therefore, any bonus plan will have to be carefully designed so that it does not directly violate this law.

Vacation

The amount of vacation given to a physician as part of a benefit package may vary according to vacation days offered by other health institutions in the same area, availability of temporary coverage, the personal needs of the physician, and as other factors.

Most medical organizations provide physicians with two to five weeks paid vacation each year, in addition to paid time-off for educational training. Management may also place the vacation schedule on a scale that allows an increase in vacation days according to physician's tenure with the organization.

When employees are terminated, they must be paid for unused accrued vacation time.

Continuing Education

Perhaps one of the most important benefits an organization can offer a physician is paid leave for continuing education. This enables the physician to fulfill educational requirements for state licensure and helps to ensure that the physician is current on applicable clinical care techniques. Keep in mind that a physician, or any other employee, must be paid for any accumulated and unused leave on termination, unless the leave is at the discretion of the administrator. Continuing education benefit levels currently average $1,000 to $5,000 per year, per physician and may include salary, travel, and educational fees.

Personal Time-Off

Many organizations offer paid personal time-off. This may be tied to tenure or based on a flat number of days per contract year. This benefit allows the physician to handle family emergencies or other unexpected personal business without using accrued vacation time. Most organizations offer three to four personal days per contract year; however, unlike other paid days off, this benefit does not accumulate year-to-year.

Holidays

The health care industry generally offers 10 to 12 paid holidays each year. There may also be a need to tailor the holiday schedule to accommodate various religious and/or ethnic holidays. When personnel are terminated, they must be paid for unused accrued holidays.

Dues and Subscriptions

This is perhaps one of the least expensive benefits that an organization can offer. Most organizations provide a flat yearly allowance for medical society dues and subscriptions to medical journals. The average amount allowed is $1,000 to $2,500 per year. Again, this benefit can be tailored to meet the specific needs of the physician.

Civic Responsibilities

An organization can offer a physician the opportunity to fulfill civic requirements such as jury duty. The written policy regarding jury duty should state that the amount of the employee's regular paycheck will be off-set by the fee the employee receives while on jury duty.

Generally, election days are not recognized for paid time-off since most polling places are open at times that are convenient to even the most hectic work schedule.

Emergency Leave

This is one of the more problematic benefits because the term "emergency leave" is often inadequately defined. The health center may be flexibile in this area if it has adequate and necessary back-up personnel. Generally, most businesses allow 10 to 30 unpaid days per year for emergencies.

The following is a sample policy for emergency leave:

"If, for some unforeseen reason, an employee is required to be away from his or her job for an extended period of time, a leave of absence may be requested. Leaves of absence may be approved for 30 days. An employee will not be paid during a leave of absence; however, all benefits will continue during the 30-day period."

Other Professional Expenses

Health centers may offer other benefits such as the use of a corporate automobile and travel expenses to meetings. Again, the type and level of benefits will vary according to the physician's professional and personal priorities, as well as the health center's ability to provide the benefits.

19. Minimizing the Cost of Benefits

The costs of providing benefits to a physician vary according to what benefits are offered and the strategy employed in linking the relative worth of benefits to the base salary. As a general industry rule, the cost of benefits will run 20% to 35% of the physician's base gross salary. The cost of benefits can be controlled by providing a level of benefits relative to tenure and experience.

TIPS FOR MINIMIZING BENEFIT COSTS

The following chart shows what can be done to minimize the cost of benefits:

Retirement Plan	If your pension and profit-sharing plans contribute a flat rate of 25% for all employees, then you are

	committed to a very expensive benefit package and a 25% increase in your payroll cost. This situation can be avoided by integrating the retirement plan contributions with Social Security benefits. This is done by building the retirement plan on top of Social Security and paying for the benefits based only on wages over the amount that government covers. Another way is to adopt a schedule of vesting that allows a departing employee to take away only a certain portion of his or her money in the pension and profit-sharing accounts, based on the length of service. It is likely that a good portion of the money the organization contributes on behalf of the employee will remain with the organization until the funds are forfeitured.
Health Insurance	Health care benefits can be tailored to the needs of each physician and perhaps tied to tenure, so that benefit levels increase with the length of service.
Life Insurance	If coverage for life insurance is set according to employment classification--so much for administrative staff, technicians, receptionist, physicians, and so on--premiums will probably be less overall than if coverage is provided according to the employees' earnings.

20. Providing Compensation For an Independent Contractor vs. Employee

An independent contractor is one who is given a task to accomplish. How the contractor completes the task is not directly controlled.

Often, it is unclear whether an agreement creates an employee-employer relationship or an independent contractor relationship. In most cases, a physician working full-time for a health center will be an employee and not an independent contractor. However, the question is extremely complex in California and, if the plan is to create an independent contractor relationship, the agreement should be carefully reviewed by a competent attorney.

By hiring a physician as an independent contractor and not as an employee, the incorporated health center saves money because it will not have to include the physician in its retirement plan and other benefit programs. Nor does the health center have to pay Social Security and employment taxes. Independent contract physicians can set up their own benefit plans.

While both sides may be pleased with this arrangement, the incorporated or unincorporated health center must be careful not to cloud the physician's status by treating him or her as an employee, otherwise there may be grave tax consequences. For example, if the IRS rules that the physician is an employee, he or she would not be entitled to have a Keogh plan, and the health center's own retirement plan might be affected. The physician and health center would also have to pay Social Security taxes.

The more flexible the arrangement, the better it fits the definition of an independent contractor. For example, it is undesirable to pay an independently-contracted physician a regular salary each week; that looks like an employee's salary. It is better to pay the physician a percent of gross billings or net revenues. However, if the physician prefers to get a regular amount of pay at set periods, then the pay can be drawn against the ultimate billing base.

Also, the independent contractor looks like an employee if he or she is not permitted an outside practice or given the right to have another physician substitute when he or she is away. An independent contractor is a free agent who can work elsewhere if he or she wishes and can employ others to work in his or her place.

Another important test is whether the physician is integrated into the organization. For example, the organization should not supply everything to the independent contractor, as it would to an employee. The physician should be required to furnish his or her own car and equipment, if possible. The physician should also pay for malpractice insurance. Of course, these costs could be shifted to the organization simply by providing the physician with less compensation.

If the contract physician is required to work a fixed schedule--9 a.m. to 5 p.m., five days a week--then the IRS will consider the physician as an employee. If the physician comes and goes at times that are mutually convenient to the organization, he or she is more likely to be considered an independent contractor. There is no harm in having a schedule, however, provided it is flexible and largely determined by the physician's work habits.

Additionally, the independent contractor's contract should avoid clauses such as "The physician agrees to be bound by any rules and regulations promulgated by the board of directors." This sort of language would be in an employment contract so it should be kept out of any independent contractor agreement.

Lastly, an employee gets vacation, sick pay, time-off to attend meetings, and possibly severance benefits. An independent contractor gets none of these. As much as the physician may want these benefits, it is inconsistent with his or her treatment as an independent contractor. As with malpractice insurance or a car, benefits can be provided in another form simply by putting a dollar value on them and adding this amount to the compensation.

A PHYSICIAN IS AN EMPLOYEE IF...

Here is a checklist to help you determine whether a physician is legally considered an employee.

Generally, a physician is an employee, not an independent contractor, if the health center--

- pays the physician a salary instead of a percent of the centers revenues
- provides all the equipment, supplies, and space needed for the physician do his or her work
- withholds income for federal and state income tax
- hires and compensates the physician's support staff, rather than the physician him- or herself
- prohibits the physician from working at other facilities or maintaining a private practice

21. Matching the Compensation Arrangement with Administrative Capabilities

Any compensation arrangement will influence the way accounting policies are designed. The peg-board or one-write system is the simplest and least expensive of all accounting systems. The peg-board system can be adapted to any compensation arrangement and provides the most comprehensive means of financial documentation. This system also provides essential historical data for future planning and development. Computerized accounting in the health industry, however, will be the rule within several years and health centers should be ready to computerize their accounting systems.

FOR MORE INFORMATION

Medical Practice Management. Horace Cotton. Medical Economics Books.

MGMA Digest of Medical Group. Medical Group Management Association, 1983.

The Art of Negotiating. Gerald I. Nierenberg. E.P. Dutton, 1981.

The Business Side of Medical Practice. American Medical Association, 1974.

The Environment of Medicine. American Medical Association, 1985.

CHAPTER THREE

SCOPE OF PHYSICIAN PRACTICE

A health center cannot rely on the belief that an oversupply of physicians will create a buyer's market when it comes to finding clinical staff. It may become easier to locate interested physicians than it was ten years ago, but unless the newly-hired clinician is content with his or her setting, it will not be long before a new search for a replacement must be undertaken. Even in areas faced with an oversupply of physicians, the current health care economy offers sufficient traditional and new opportunities--ambulatory emergi-centers, health maintenance organizations, emergency room contract work, and so on--utilizing physician manpower with which community health centers must compete in the physician marketplace.

Therefore, the nature of the clinical setting, in addition compensation, is important. While it is true that the physician who is not satisfied with compensation arrangements will separate from the practice, it is no less important that a physician will leave a practice if it does not satisfy his or her workplace requirements.

Nonmonetary considerations that influence a physician's decision to both choose and remain at a particular practice include--

- range of services provided
- availability of peers
- ability to participate in decision making
- governing and operating policies
- new reimbursement programs
- physician compensation arrangements
- possibility of taking over practice.

Of course, there are many other considerations weighed by a physician in selecting and remaining at a clinical site, but these are generally out of the scope of matters that can be controlled; namely, the availability of schools, cultural activities, climate, and so on. Here we focus the discussion on those areas that can be managed by the employer.

22. Providing a Range of Services

Physician staff, like any other staff, will enjoy the workplace more if there is a variety of activities in which to participate, rather than the sole prospect of straight clinical medicine. This can include health education, community meetings, staff development and training, program planning, community health projects, and hospital practice.

Community health centers generally offer many such opportunities for a varied work day; however, if the scheduling of clinical hours leaves limited or no time except before and after work for becoming involved, the physician will opt out of participating in such activities.

Likewise, if the contract agreement requires that the physician provide inpatient care but the clinic schedule does not provide some early morning time for hospital rounds, then the irreconciled difference between intent and ability will result in stress arising somewhere in the system: between management and physician; between physician and patient; and so on.

Clearly, there are appropriate and inappropriate activities with which to involve the physician. While a grant proposal may be better and more easily written by an administrator, the program design--if it will make use of clinical services or professional staff time--should at least be reviewed by the medical staff before the proposal is submitted for funding consideration. Some ideas may be feasible, but will impact on other activities in the organization, the repercussions of which must be understood beforehand.

For example, a supplemental food program to be integrated with prenatal care may extend by ten minutes each physician prenatal visit due to the additional reporting and examination required by the funding source. If the medical staff is consulted, it could perhaps suggest a program design modification that would shift activity to other staff without cutting into the physician's clinical time. Without such consideration and introduction of changes to either lengthen appointment times or shift responsibilities, the system of care becomes stressed by attempting to meet overly difficult goals. Such stress will show in either system failure or staff (physician) burnout which, in turn, results in staff turnover.

Physicians are trained in highly technological settings and rely on such support in their practices. By not having reliable ancillary medical services available either on-site or through contract, the physician does not have the necessary tools to practice his or her art. The practice, therefore, becomes frustrating to the physician and is likely to be characterized by a high referral rate for diagnostic and/or therapeutic services. Even a small practice can offer sufficient ancillary support through contract or minimal investment for purchasing or leasing equipment. All such services are billable and will produce revenue to offset their costs.

23. Providing Back-Up for Physicians

The best source for recruiting and keeping physicians in a health center is a satisfied physician already in the practice. Because of the on-call and 24-hour nature of most practices, it is necessary to assure the availability of more than a single physician to cover a practice. Without back-up, many of the required and desirable services such as inpatient care, home visits, and night or weekend clinics cannot be offered. Moreover, the physician will not be able to take time off for personal reasons or to complete continuing education requirements.

While mid-level practitioners (MLPs) can ease the burden considerably, a physician must be available as a back-up. The physician's ability to "turn-off" the practice will be absent if there is no physician peer with whom responsibilities can be shared.

Furthermore, MLPs require the physician's time for supervision, consultation, chart review, training, and so on. Adding an MLP to a practice does not result in a geometric unburdening of physician time. In most instances, the MLP will ease demands for routine physician care but will replace those less demanding visits with increased supervisory commitments and more complex cases, which before were frequently referred off-site.

If there are MLP supervisory responsibilities, they should be clarified in the employment agreement with the physician. This clarification should set time allocations for supervision and explain how those responsibilities fall within or outside of the clinic schedule.

24. Offering the Opportunity to Participate in Decision-Making

The single greatest cause for physician turnover in community health centers--apart from personal considerations such as marriage and family demands--is not reimbursement (except in rare instances where salary is unnaturally low) but the sense of powerlessness experienced by the health professional who has no avenue for affecting the structure of his or her work environment.

While the demystification of health care and its organization is a goal in many community health centers, the training and socialization of medical students into physicians typically results in a tendency toward ego strengthening, a fact that is overlooked in many community-based organizations. The physician, as all other employees, must experience a recognition of his or her power to influence decisions concerning the factors affecting work--choosing scope and availability of service parameters, hiring and firing staff, developing and evaluating programs--if he or she is to possess a sense of commitment to the organization. Although the physician may not be able to readily verbalize his or her concerns, management should not assume such factors are not important. The critical element in this issue is that the board and management **offer** physician staff the opportunity to influence decision-making in the organization.

The intent will be reenforced by assuring that the organization has a well-functioning senior management team in place; by requiring the medical director to report to and interact with the board at its monthly meetings; or by establishing ex-officio, non-voting positions on the board of directors for both the executive director and medical director of the health center.

Regulations governing federally-funded health centers do not allow staff to have voting membership on the board of directors. Therefore, non-voting, ex-officio membership may be the only acceptable manner of providing direct physician input into corporate decision-making. However, those organizations which are not prohibited from allowing the staff physician to be a voting member of the governing body may wish to establish such a position on the board. The advantages to the physician by becoming a voting member of the board are clear; the disadvantage to the board may be the growing dominance of provider input at the cost of losing patient perspectives. Such an arrangement, as any other, must be managed with consciousness and sensitivity to competing community health center interests.

25. Designing and Implementing Clear Governing and Operating Policies

The range in quality of health center policies and procedures runs from excellent to poor. Curiously, a complete set of policies does not always imply a healthy organization; the opposite is also true. It is the manner of **implementing** policies and procedures that colors the ambiance of the health center.

Notwithstanding acknowledgement of the importance of appropriate policy implementation, the policies themselves should be well-conceived, thorough, and well-attended. Usual causes for conflicts in the health center organization can be avoided if governing policies and procedures are developed that clarify the expected behaviors and goals of the employment relationship.

When recruiting a physician, an organization may be reluctant to make known all of its expectations for fear of overwhelming the candidate. However, by not being clear from the beginning about desired work objectives--both on the part of the organization as well as the physician--the seeds of an eventual conflict are being sown.

THREE POLICY ITEMS TO CONSIDER

Typical operating and governing policy items addressed should include:

1. Scope of services to be provided by the physician. Services such as night call, hospital practice, community involvement, and hours of clinical services to be provided should be specified.
2. Performance requirements should be specified in clear, meaningful job descriptions, including supervisory responsibilities, administrative duties, and productivity expectations.
3. The organizational standing of the physician with respect to decision-making authority and reporting within the organization should be specified in organizational charts, administrative policies and procedures, personnel manuals, and in the bylaws of the governing body.

If the expectations of the physician are different from those of the health center, the surest way of clarifying areas of difference is by defining expectations through clear policies and procedures. Written policies and procedures should not be seen as static and immutable: as good management knows, opportunity should also influence the structure of an organization so that flexibility in goals and objectives may be considered appropriate. However, the base for negotiating change should be clearly established so that at any one time, all parties in an organization have no doubt that their expectations are understood.

26. Mitigating the Impact of New Reimbursement Programs

Health care service reimbursement policy has been changing dramatically in recent years. Fee-for-service payments by both public and private insurance sources are being eased out of central revenue source importance by discount and capitation arrangements.

Opportunities for health centers to secure new or additional revenues have attracted these organizations to enter into contractual agreements that may cause unforeseen repercussions in the health delivery organization, frequently affecting the physician staff in ways that may disenchant the practitioner.

For example, many physicians choose the health center environment as the most desirable workplace because of its commitment to providing care to the medically underserved. However, the introduction of a prepaid health plan contract may be seen as a cause for displacement of the original target patient population. The physician may feel that the organization has become co-opted from its founding mission.

Additionally, the introduction of new payment schemes may necessitate changes in the scope of practice such as requiring that a hospital practice, as well as an ambulatory care service be developed; referrals be prior-authorized; or only specified hospitals be utilized.

While such changes may be desirable from a view towards improving both the finances and quality of care of the health enter, an unprepared--or improperly prepared--physician group may reject the changes by terminating services or by creating discontent among staff in reaction to the changes.

Once physicians are appropriately informed and offered the opportunity to contribute to the planning and decision-making cycle, the introduction of new payment programs can serve as a catalyst for reinvesting a sense of challenge and new purpose into an organization. For example, capitation payments can provide the appropriate income source for introducing incentive pay bonuses into the physician reimbursement plan; or successful utilization control can result in the generation of income surpluses that can be programmed to support special services for the uninsured. Therefore, depending on how the changes in reimbursement mechanisms are marketed to the physician staff, the opportunity can increase organizational cohesiveness and strength or be a divisive force in the health center.

27. Matching Physician Compensation Arrangements and Health Center Goals

Earlier sections of this guidebook describe typical as well as unique ways of structuring compensation arrangements with the physician. Later sections describe how such arrangements are formalized in contract. This section will briefly address the ways in which compensation arrangements can affect the nature of the clinical practice.

- **Salary only** may not provide the appropriate inducement for achieving required productivity norms.

- **Base salary and incentive based on clinical productivity** may result in an episodic care-oriented practice because of an intent to generate many clinical visits.

- **Base salary and incentive based on inpatient billings** may result in too large of an inpatient practice to the detriment of the ambulatory clinical service, unless the base salary is fair and competitive.

- **Percentage of gross billings (or collections) with no base salary** may compromise quality of care for volume.

The most desirable compensation arrangement then is one based on clear performance expectations and attention to how those expectations fit with the health center's mission, goals, and objectives. In negotiating the employment contract, the reimbursement arrangement itself is extremely important because of its influence on the characteristic of the clinical practice and physician participation in the organization. If the organization is seeking administrative assistance from the physician, then the compensation agreement cannot be only productivity-based because the physician is not being compensated when he or she does not see patients. And, as suggested elsewhere, if the organization considers the physician only as a technician, then it misses the opportunity to have the physician "invest" him- or herself in the organization, building loyalty and better assuring physician retention in the organization.

28. Reexamining Health Center Ownership

Some smaller--particularly rural--communities come to be involved in collective action around health care because of the identified common need to bring a solo or group practice of physicians to their area. Because of availability of federal and/or state financial aid, such groups incorporated and went into the health care business. The movement which supported the development of community clinics did much to empower nonmedical community members with the ability to bring needed health care resources to underserved areas.

At some point, however, the reality of the community should be reexamined to determine whether or not there still exists a need to continue the venture in the same way. If the community clinic has been successful in generating revenues from services, perhaps the need to continue receiving governmental financial support may no longer be strong: in fact, the "strings" attached to such support may be more trouble than the support is worth. Without such support, the whole regulatory panoply changes, including requirements established for makeup of governing bodies and the corporate tax structure.

If the practice has been financially successful, the physician(s) working at the site may wish to acquire it. This possibility should be considered by the community because it can provide the final solution to the problem that first activated the community. A serious assessment of the matter of **ownership** should be undertaken, which should include an evaluation of options that best meet the current needs of the community. The strongest inducement for retaining any member of a community--whether a storekeeper or physician--is the size of his or her financial investment in that community.

29. Boosting Physician Recruitment and Retention

After analyzing the scope and principles of practice at a community health center, one could say that the surest way to attract and retain a physician in a practice is to:

- pay a good salary
- offer a well-equipped staff and facility
- allow the physician to have a meaningful role in management decision-making and program design
- assure that he or she is not the only physician responsible for the practice
- provide for reasonable policies and procedures that are reasonably implemented
- introduce changes in a way that is sensitive to physician needs.

Each of these factors is important, but only if undertaken in a spirit that recognizes the physician as an individual who is more than a clinician. In an attempt to demythify the medical care system and establish "lay" control, the physician is occasionally forgotten as a person who is more than a clinician. More often than not, the non-clinician aspect of the physician is the operative element in recruitment and retention dynamics.

No matter how much one wishes to minimize the power of any one individual in an organization, the central role of the physician in the health center must be recognized. Whatever other personnel management practices may be in place, the establishment of the concept of the physician as a partner--not merely as an employee--in the venture is paramount to fostering a positive connection between the health center and the physician as a person. The relationship need not be overly conciliatory to the physician, but it should be founded on a "win-win" footing for both the health center and the physician.

CHAPTER FOUR

PHYSICIAN EMPLOYMENT CONTRACTS

NEGOTIATING CONTRACTS

Contract negotiation is the process by which the wants and needs of the physician are matched with the wants and needs of the health center. Negotiations are an expected part of establishing a contract. Although the process often conjures up images of a smoke-filled room with persons haggling over a long table, this rarely happens.

The process of negotiations is often as important as the result. Therefore, deciding **who** is going to negotiate on behalf of the board and **how** they are going to conduct negotiations are crucial considerations.

30. Selecting the Negotiator

First, the board must select a sole negotiator. To keep the interests of the board and the community paramount, the person must have both the full trust and confidence of the board and the flexibility to accommodate the physician's priorities. The board must also give the negotiator clear guidance and support. Any indication that the negotiator does not have the board's clear direction or full confidence undermines the negotiator's bargaining position and invites discussions and pressure from outside the formal negotiations.

The negotiator need not be a board member. If the health center has a full-time administrator, this task can be delegated to him or her in the job description.

31. Ascertaining the Physician's Needs and Wants Before Negotiation

Often, the negotiations determine the course of the future relationship between administrator and the physician. Therefore, it is important that the administrator conduct a pre-negotiation assessment of the wants and needs of the physician while also focusing on the health center's ability to accommodate those needs.

The recruitment phase offers the health center its most important tool in contract negotiation--information. The physician will reveal information about his or her wants and needs, leading to successful negotiations. Factors that should be considered by the health center during recruitment are--

- **Dollars**--What are the physician's financial needs? This can include outstanding student loans or need for a down payment on a house. While it may be inappropriate to confront a physician recruit with these questions, the answers are often revealed during the recruitment phase.

- **Vacation/time-off**--Many physicians today are motivated by "quality of life" issues. More time off is often an effective incentive, even if it means less pay.

- **After-hours duty (call)**--This is foremost in the minds of all physicians. How much call, when it is, and with whom it is shared need to be considered prior to recruitment. For example, hiring an emergency physician one weekend a month will relieve the pressure of weekend call on the regular medical staff. Rotating weekday and after-duty call by weeks rather than days may be more acceptable.

- **Fringe benefits**--Different benefits for different employees is becoming more and more popular. Consider auto stipends, deferred compensation, and other innovative benefit packages. The limit is the imagination, inventiveness, and flexibility of the parties.

- **Administrative duties**--Some physicians will be content with only a medical role; others will want to play a part in the administration and management of a health center. By being flexible, a health center can cater to both approaches. If a physician accepts both a medical and administrative role, it is important to formally recognize the two roles so the physician will not feel abused.

For purposes of negotiation, the physician must be regarded uniquely. The physician is well-educated, comes from a very structured environment, and most likely has preconceived notions about the outcome of the negotiations. The health center may need to be innovative and flexible in areas such as compensation and benefits. Attempting to make the physician conform to existing standards--personnel policies or a group insurance plan--may be a mistake, costing the health center a valuable asset.

For example, a health center may plan to spend up to $60,000 a year ($50,000 plus 20% fringe benefits) on a new physician. By restructuring the compensation package to meet the needs of the physician ($55,000 and fewer fringe benefits; $50,000 and increased time-off), the health center can enjoy another satisfied employee without spending extra dollars.

32. Conducting Negotiations

Negotiations should be scheduled at a mutually convenient time and place. Successful negotiations are those conducted in an atmosphere of honesty and fairness, free of tension and distrust. Both parties should have an agenda of items to discuss and on which to agree. An inventory of basic contract provisions is a good beginning guide to items that should be considered. (See section on contract provisions, beginning on page 54.)

Before the first meeting between the physician and the negotiator, the negotiator should know which contract elements are negotiable and which are not. The negotiator should know the board's stand on each item on the agenda, its place of relative importance for the organization, and the upper and lower limits of authority that the board has given the negotiator. It is crucial that the negotiator have clear directions from the board, ideally in form of a motion.

Once negotiations have begun, all board members and health center employees should refrain from contract discussions with either party. Only in the context of a committee or full board executive session should details of the negotiations and/or the contract be discussed.

33. Monitoring Negotiations

Recognizing the bargaining strengths and weaknesses of both parties is important to the negotiation process.

Physician Bargaining Strengths

The physician's bargaining strengths in negotiations include--

1. A position of strength, if the health center has few qualified applicants, pressuring the parties to act like it is a seller's market. If the community and staff are positive about what they have to offer, the position looks more attractive and the "who else can we get" posture is neutralized.

2. Power and mystique of title. The intimidation factor: the physician is the medical expert and as such, has the health center focusing on his or her title rather than his or her professional and personal qualifications as they suit the position. The health center should remember that it is bargaining for an integral part of the health care team, not a framed license.

3. Relationship with staff, patients, and board members, for the physician who is renegotiating an existing contract. When the physician is made to feel like he or she is a valued asset, that value translates into negotiating strength. When there is basis for the sentiment, the strength is deserved and should probably be compensated.

4. Environmental factors. Common knowledge that the community is geographically undesirable can give the physician leverage in the negotiating process.

5. Cultural factors. A physician who is of the ethnic minority that the health center predominately serves or who speaks the language of the nonEnglish-speaking patients, will have his or her currency increased.

Health Center Bargaining Strengths

The following are the health center's strengths in negotiations:

1. The board's support of the administrator during the negotiating process. This applies mostly to renegotiations. If the physician knows that the board is behind the negotiator, there is less room for an end run. If this support is not evident, the physician can circumvent the process.

2. The rapport the administrator has with staff and other medical providers. If the administrator as negotiator has a good solid working relationship and knowledge of the staff dynamics, the administrator will be less susceptible to a charge that the administrator does not understand medical needs. Such charges undermine negotiating authority.

3. Reputation and history of the administrator and health center as fair and honest bargainers. When the physician knows, feels, and understands from others that he or she will get a fair and honest deal, the physician will negotiate from a position of comfort rather than insecurity.

4. Environmental factors. The geographic desirability of the community: the employment of a friend of the candidate by the center, the security of family nearby, and the ability to meet special spousal needs, will all contribute to the health center's bargaining strength.

34. Negotiating with Private Practice or NHSC-Obligated Physician Candidates

Community health centers commonly contract with two types of physicians: the private physician and the National Health

Service Corps (NHSC)-obligated physician. While negotiating strategies and tactics for both types of physicians are similar, there are some basic differences.

The NHSC private practice option (PPO) physician does not have the choice and mobility of the private physician. The PPO physician is hired at federal pay scales which are often less than private, more competitive rates. It is important, however, to bargain in good faith and fairness. The retention level of NHSC physicians is low and turnover only hurts the health center.

PROVIDING A CONTRACT

A contract is a mutual agreement, usually between two parties, which describes the responsibility each has toward one another. It may be written or oral, and is enforceable in court. Only in a few specified instances, not relevant here, must contracts be in writing. Other than these, an oral contract may be valid.

Many contracts are sealed with a handshake. With physician employment, however, it is preferable to have the complete understanding in writing. One prominent advantage of a written agreement is if the administration or membership of the board of directors changes, or the memories of the parties fade, documentation exists regarding the agreement at the time of execution.

The written contract can have varying degrees of formality beginning with the letter of agreement. The letter of agreement is merely an acknowledgement by one party that the employment relationship has been discussed. It represents the writer's understanding of the terms. The letter is usually one or two pages in length and concludes with a paragraph stating:

> ...unless we hear from you to the contrary by [date], we will assume that these terms represent your understanding of our agreement.

While the letter of agreement is one-sided, it will reinforce the health center's position in enforcing a provision that has been reduced to writing in the letter of agreement, especially if the physician made no response.

More formal is the employment agreement or employment contract. The contract is the final product of the negotiating process in which the parties, presumably in equal bargaining positions, have discussed and agreed to specific terms. Once both parties sign the agreement, it becomes binding on each of them.

Going through this formal process is the advantage of a contract over a letter of agreement. The negotiation and writing of a contract take on a "checklist approach" to the numerous issues that you may or may not want to agree on in advance.

35. Minimizing Pitfalls of Contracts

The common pitfalls in negotiating and writing contracts include cutting and pasting together parts of different contracts to make a new one or adopting other contracts without a serious review of their terms. Every contract is unique and should be approached as a new product made from whole cloth, not a ready-made one merely modified here and there.

Reviewing contractual issues sometimes puts the parties in an adversarial relationship, resulting in a loss of some of the informality and comraderie of recruitment.

Often the parties will not have the contract reviewed by "clean eyes"--a reasonably intelligent person who is familiar with the situation but who does not have any personal interest in it. Does someone like this reading the contract understand what is meant by all of the terms? If a reasonable, disinterested third party cannot understand the agreement, then it should go back to the drawing board.

36. Ensuring Comprehensiveness and Specificity

Two general areas that should be kept in mind throughout drafting a contract are its comprehensiveness and specificity. Remember, in negotiating an initial contract the bargaining positions are more equal than in re-negotiating or modifying a contract where a physician's bargaining position is greatly strengthened by his or her incumbency.

Comprehensiveness What areas do the parties want to touch and agree upon? While some assume that the more that is addressed, the better the agreement, this is not always true. Some items may be better left unaddressed until the parties have had experience with each other.

Moonlighting is one example. The health center may have had bad experiences with physicians moonlighting in the past and the current physician has no immediate plans to moonlight. The parties may decide not to include reference to moonlighting in the contract. By doing this, the parties are relying on the good will of each to work out an arrangement if the need arises.

Conversely, the parties may want to specify that moonlighting has been discussed and no agreement has been reached. A simple statement that "No agreement has been reached concerning the issue of moonlighting" will serve this example by making clear that this issue was not excluded by oversight.

Short-term contracts of no more than one year or modification provisions give parties the flexibility of retooling the agreement as the situation and need demands.

Specificity Vague language gives parties room to move, the degree of vagueness accommodating multiple interpretations within a defined limit.

For example, the parties may agree that five days will be allocated for continuing medical education. From least to most restrictive, the document may state that the five days are

...for continuing medical education.

...for continuing medical education related to physician's duties.

...for the improvement of skills directly related to physician's duties.

...for certified continuing medical education courses directly related to physician's duties.

...for certified continuing medical education courses directly related to physician's duties approved in advance by the health center.

...for certified continuing medical education courses directly related to physician's duties which have been selected by the health center.

37. Determining the Physician-Health Center Relationship: Employee or Independent Contractor

Before pen is put to paper, the basic nature of the relationship between the health center and the physician should be determined. This is an important point of negotiation because the whole attitude toward the relationship depends on whether the agreement is with the physician as an **independent contractor** or as an **employee.**

The decision will determine how worker's compensation, employment benefits, and certain personal and organizational tax procedures are treated. For example, employees will have part of their incomes withheld for federal and state taxes. They can participate in deferred compensation, retirement, and fringe benefits. On the other hand, independent contractors pay their own self-employment and social security taxes and are responsible for their own retirement and other fringe benefits.

Whether the physician is an independent contract or employee can also affect liability of the health center. For example, if the health center can establish that it exercised due care in selecting the physician as an independent contractor, the health center may not be liable for any of his or her negligent acts or omissions in performing under the contract. It is wise for both the health center and physician to consult financial and legal professionals to guide their decisions in this area.

Because most health centers today relate to physicians as employees, the following discussion reflects the physician as an employee rather than an independent contractor.

38. Deciding the Parties in the Agreement

To ensure there is no personal liability by the negotiator or signatories of the contract, it is important that the corporate entity is party to the agreement. Is the physician a professional corporation or will the physician be contracting in his or her personal capacity? Are there any other parties that should be made part of the agreement?

For example, if a state, federal, or private agency has agreed to pay part of the compensation, the corporate entity may want to make the agency part of the agreement.

> This AGREEMENT, made and executed in duplicate this xx day of Xxxxx, 19xx between xxxxx Health Center, Inc., a California corporation (hereinafter referred to as HEALTH CENTER) and xxxxx xxxxx, M.D. (hereinafter referred to as PHYSICIAN).

39. Choosing Contract Elements

A number of issues should be considered in the contracting process. While each issue may not find its way into the final contract, a systematic approach will insure that an omission will not be due to error but to a thoughtful decision to either deal with the issue in another context (in personnel policies, for example) or to dismiss the issue as irrelevant to the situation.

A list of contract elements with sample language follows. The list is not exhaustive, although every effort has been made to include all topics. Over the years, the board and administration can develop their own additions to this list based on their experience and the changing demands of the health center-physician relationship.

Whereas Recitations Basic assumptions about the physician and the health center should be clearly spelled out in the agreement. This can be done in a paragraph that identifies the parties and the assumptions, and is preceded by the word **WHEREAS.**

When one of the assumptions is no longer valid, the purpose and implementation of the contract may be materially affected, and may render the contract unenforceable.

Physician and clinic licensing can be handled in WHEREAS clauses as follows:

> WHEREAS, PHYSICIAN is licensed by the State of California and certified by the American Board of Obstetrics and Gynecology.

> WHEREAS, PHYSICIAN is, or will within xxx days of the effective date of this AGREEMENT, qualify as an active member of the medical staff of Happy Heart Hospital with all of the privileges and subject to the professional supervision of the executive committee of the medical staff. It is expressly agreed that continuation of this AGREEMENT shall be dependent on PHYSICIAN's continued active membership on the medical staff of the hospital named above.

> WHEREAS, PHYSICIAN is or will be within xxx days of the effective date of this AGREEMENT certified to supervise physician's assistants under California state law.

The WHEREAS part of a contract is also a recitation of the major goals for which the health center and the physician have joined together. While the WHEREAS clauses are regarded by some individuals as a boilerplate or mindless recitation of empty phrases, they can be used effectively to set in writing some idealized goals specific to the community, the physician, and the health center.

Examples of some standard, specific, and creative goals follow:

> WHEREAS, the PARTIES desire to provide competent health services at fair and reasonable costs to patients.

> WHEREAS, the PARTIES agree to work cooperatively to develop nurse-midwife services.

Definitions Often it is helpful in detailed contracts to include a section defining the terms to be used. Throughout the contract, these terms are then capitalized when used. The reader is alerted that these terms have a meaning specific to this contract, avoiding confusion. The rule of thumb is: define any term used more than twice; any term of art or any term subject to nuances of meaning; and any term to be restricted or expanded by agreement of the parties.

For example, the contract may refer several times to the personnel policies. The contract could be structured to refer to PERSONNEL POLICIES and the definition section would include:

> PERSONNEL POLICIES: Those policies adopted by the Board of Directors of the HEALTH CENTER on Xxxx, xx, 19xx and incorporated herein by reference and attached hereto as Exhibit A including any modifications adopted by the Board during the term of this AGREEMENT.
>
> Other definitions may include--
>
> DAYS: All days in this AGREEMENT refer to calendar days. If the last day falls on a Saturday, Sunday, or federal or state holiday, the next working day is counted as the last day.
>
> WRITTEN NOTICE: Any written notice to any of the parties to this AGREEMENT shall be deemed to have been duly given on the date of service if served personally on the party to whom notice is to be given, or on the third day after mailing, if mailed by certified mail to the party to whom notice is to be given and addressed to the addressee at the address stated opposite the parties named below, or at the most recent address specified by written notice given to the sender by the addressee under this provision.

Compensation Clauses The compensation clause of the contract will vary with the method of reimbursement. Included here are sample clauses for some of the compensation plans discussed earlier. It should be remembered throughout the negotiations on compensation that money is not always the primary issue and that compensation is more than monetary.

In putting together compensation arrangement for the physician, the give and get of negotiation takes place. Fringe benefits such as vacation time, modified scheduling, sabbatical periods, and support for research and continuing medical education are points to be considered under the heading "compensation" and trade-offs can be made among and between--more continuing medical education, less vacation, more money, less call, more call-time, less clinic hours, and so on.

Salary Salary, one of the most straight forward of clauses, is probably the central issue of the negotiations. The salary is a straight cash payment for services rendered.

> In return for services contracted for herein, PHYSICIAN shall receive a salary of $xxxx per year payable in 24 equal installments.

Percentage and Incentive Clauses There are many types of percentage arrangements that a health center may make with a physician. These arrangements can be complicated by the requirements on the use grant or contract funds. This should not dissuade you from entering into a percentage or incentive agreement, rather you should carefully consider the approach that most clearly meets your expectations.

Listed below are examples of clauses to consider. The more complex the arrangement, the greater the need for good fiscal controls and timely financial reports. Otherwise, frustration by the physician will quickly replace the motivation you are trying to promote.

Percentage Arrangement (base salary plus percent of net income):

> From the total HEALTH CENTER charges for one full calendar month, HEALTH CENTER shall deduct x% of inpatient services and x% of outpatient services as allowances for bad debts. There shall also be deducted all costs incurred as set forth in paragraph x, below. Of the remaining amount, x% shall be PHYSICIAN compensation, which shall be paid to him/her with the monthly statement of gross income and expense of said calendar month but in no case later than 15 days after the close of the calendar period. The remainder thereof shall be retained by HEALTH CENTER as reimbursement for the cost of HEALTH CENTER services. The above percentages for departmental bad debts shall be adjusted every six months in order to reflect the record of bad debts for the previous six month period, based upon the collection experience for that period.

Note that the language used does not reflect grant or contract income that the health center may be receiving.

Percentage Arrangement (percent of gross income, no salary):

> Of the total HEALTH CENTER gross charges generated by PHYSICIAN (including outpatient and inpatient charges) for the contract period, PHYSICIAN will be paid x%.

This is a straight percentage arrangement. The calculation is simple. However, this approach can have a negative impact on quality of care. The contract language from the above example can be used for payment and reporting.

Percentage Arrangement (percent of gross income, in excess of base amount):

Of the total HEALTH CENTER gross charges generated by PHYSICIAN in excess of $x per (month) (quarter) (etc), PHYSICIAN will receive x% of such amount in excess of $x per (month) (quarter) (etc).

This is the most common of all percentage arrangements. It combines the simplicity of the percentage of gross with an expected level of charges. This arrangement often combines a fixed salary with the incentive.

Notice that the period of time in which the incentive is calculated is variable and should be negotiated. Generally, the longer the period of time for which the calculation is made is to the advantage of the health center. This allows for the peaks and valleys in the number of encounters. However, the concept is to provide an incentive and the longer periods of time may diminish the effectiveness of the plan. A compromise where the health center retains a portion of the incentive and then makes an annual reconciliation with the physician provides the necessary physician motiviation while protecting the health center. An alternative is to vary the agreed upon level of charges, better reflecting the peaks and valleys of the actual practice.

Fringe Benefits Fringe benefits and perquisites are major contract elements. If the agreement is to provide all of the fringe benefits available to other employees, those personnel policies should be alluded to, incorporated by references, and attached as an exhibit. For example:

PHYSICIAN shall be entitled to all fringe benefits available to all employees of HEALTH CENTER as set forth in HEALTH CENTER PERSONNEL POLICIES adopted by the Board of Directors on Xxxx xx, 19xx, attached to this AGREEMENT as Exhibit X, and incorporated herein by reference.

Fringe benefits may also be handled item per item in the context of paragraphs in the contract.

Scope of Practice The balance between medical services and administration has always been a delicate one. It is helpful for the parties to discuss and reduce to writing the health center's administrative role and the physician's medical role, and the crossover between the two. Here the physician and health center can set forth their specific expectations.

Medical (or Dental) Services The following clauses describe the kind and quality of services: medical, dental, or other. Any special services or duties that the physician is expected to undertake, or any prohibitions can also be set forth in the contract. (See the clause regarding outside employment for an example of a prohibition.)

> PHYSICIAN agrees to act as preceptor of a certified nurse practitioner to be hired by HEALTH CENTER with the approval of PHYSICIAN.
>
> PHYSICIAN agrees to comply with the PERSONNEL POLICIES, rules, and regulations of HEALTH CENTER.
>
> PHYSICIAN shall confine his/her practice to the HEALTH CENTER except when practice at other institutions or locations is agreed to by the governing board of HEALTH CENTER in an appropriate document.

Productivity Sample language follows if the health center wants to establish specific goals regarding productivity on either the basis of time spent or patient encounters. Terms like "patient encounters," however, should be defined either here or in the paragraph of DEFINITIONS, as explained earlier.

> Beginning [date] PHYSICIAN agrees to provide a minimum of 4,200 patient encounters per year or 350 per month.

Probationary Period For an initial contract with a new physician, some consideration can be given to probationary issues such as productivity, termination with and without cause, educational and vacation leave, and evaluation. These issues can be handled separately in their respective clauses or stated under a paragraph headed PROBATIONARY PERIOD.

> PROBATIONARY PERIOD: One hundred eighty days commencing with the effective date of this AGREEMENT.
>
> During the PROBATIONARY PERIOD, PHYSICIAN can be terminated by HEALTH CENTER upon 14 days written notice if, following written notice that his/her performance is unsatisfactory, no improvement is noted.

Administrative Services Normally, the health center will agree to provide the necessary support services and facilities permitting the physician to provide medical services. This can be as specific as the parties want and include such items as new equipment or expanded pharmacy.

> HEALTH CENTER agrees to perform or have performed all of the necessary administrative, accounting, enrollment, and other functions in support of the medical services to be provided. (See Section xx above)

> HEALTH CENTER agrees not to intervene in any manner with the rendition of medical services. The sole interest and responsibility of the HEALTH CENTER is to ensure that services covered by this AGREEMENT shall be performed and rendered in a competent, efficient, and satisfactory manner.

Schedule and Call Numerous articles have been written about scheduling and call procedures. If clinic hours, hospital rounds, and emergency-call schedules are covered in the personnel policies, then they can be incorporated here by reference. If a special formula has been developed to account for rounds, call and office time, that also should be included here.

> PHYSICIAN agrees to be available to provide medical services at the times set in the HEALTH CENTER POLICIES adopted by the Board of Directors of HEALTH CENTER on Xxxx, xx, 19xx and incorporated herein by reference and attached to this agreement as Exhibit X.

> PHYSICIAN further agrees to be "on call" after regularly scheduled business hours in rotation with other physicians of the HEALTH CENTER in such a manner that health services are available 24 hours per day, 7 days per week.

Evaluation/Quality Review Some provision for periodic professional review of physician competence should be included, if it is not found in the personnel policies.

> PHYSICIAN performance of medical services provided under this contract shall be evaluated on 15 days written notice, 180 days after the effective date of this AGREEMENT. The evaluation shall be conducted in accordance with procedures set forth in the PERSONNEL POLICIES.

Noncompetition Clause A range of considerations exist, which are beyond the scope of discussion here, concerning physicians who establish a patient population at a health center, then terminate the contract (or on expiration of the contract) to establish a private practice in the same community, in direct competition with the health center.

Standard business agreements provide noncompetition clauses in contracts. For example, a shopping center lease with a particular franchise may specifically prohibit the operation of another outlet of the same franchise within 50 miles during the term of the lease and for one year after the lease terminates.

Such clauses are subject to antitrust considerations, an area of health law now fast developing. It would be prudent to consider this issue and consult with competent legal counsel.

In some cases, competition is handled indirectly through contract timing; that is, ending the health center's lease agreement after the end of the employment contract.

Except in special situations where the physician has an equity interest in the clinic business, most noncompetitive contract provisions are unenforceable in California.

If this issue is of concern, it should be discussed even if no written understandings or assurances are made.

> Upon termination of PHYSICIAN'S employment for any cause, PHYSICIAN, at PATIENT's request and expense, shall be entitled to a copy of the case histories of patients that PHYSICIAN has attended while rendering medical services on behalf of HEALTH CENTER.

> Upon termination of this AGREEMENT at any time and for any reason, the medical records of HEALTH CENTER shall be retained by HEALTH CENTER at the HEALTH CENTER. PHYSICIAN shall have the right to have copies made for his/her own use at his/her own expense.

Hold Harmless Clause Depending on what arrangements are made for professional liability (malpractice) insurance, a hold harmless clause might be included. This should be discussed with informed insurance agents and competent legal counsel because the issue centers around the assumption of liability in personal injuries sustained as a result of a party's action or inaction.

> PHYSICIAN shall be responsible for the quality of care rendered to the PATIENTS and shall hold harmless, indemnify and defend the HEALTH CENTER, its administration, officers, directors, and trustees from any litigation costs, claims, judgments, liability and damages resulting from the medical, surgical and/or

> dental care rendered to PATIENTS under this AGREEMENT, including any legal damages, costs of adjustments or investigation, attorney's fees or any other costs.

Hold harmless clauses should always be linked with the insurance clauses. For example:

> PHYSICIAN shall maintain, at PHYSICIAN'S expense, professional liability insurance in the minimum amount of $1,000,000 per occurence and $2,000,000 aggregate per policy year. A certificate of such insurance shall be furnished to HEALTH CENTER at the commencement of this AGREEMENT and thereafter upon the reasonable request of HEALTH CENTER. PHYSICIAN shall promptly pay all premiums for this insurance when due and shall notify HEALTH CENTER if any payment is delinquent.

Termination The time period of a contract may have some management considerations beyond the substance of the contract itself. The astute health center will consider the timing of the contract period in relation to other management cycles. Initially, a contract may need to be for shorter or longer period of time to synchronize the physician employment period.

For example, it may facilitate financial management if the contract period is the same as the health center's fiscal year, a federal or state grant cycle, or other physician contracts. On the other hand, the health center may want the physician contract to terminate one month after the end of a grant cycle so only one month obligation would be incurred if the grant were terminated. Or, the health center may want to have the contract terminate several months before the end of the lease for the health facility, assuring the health center of staffing before entering into a new lease.

Term of the Agreement The effective date of the contract is the time from which most other dates in the contract are measured. Also to be considered is the length of time that the agreement will be in effect, providing all goes as expected.

The termination date can be conditional--until another physician begins to work or until specific funding is terminated--but it is suggested some point of termination be included.

> This contract shall continue in effect for a period of two (2) years beginning with the xx day of Xxxx, 19xx and ending on the xx day of Xxxx, 19xx.

> This contract shall commence on xxth day of Xxxxx, 19xx and shall continue until HEALTH CENTER enters into a contract for prepaid group health services with the

> State of California, but in no case later than the xxth day of Xxxx, 19xx, unless an extension is mutually agreed to, in writing, by the PARTIES.

Evergreen Clause If a termination date has been fixed on the contract, it is customary to insert a clause that provides for the contract to continue, on the same terms, month-to-month until a new contract is entered into or terminated on specified notice without cause or according to the termination-with-cause provision of the contract.

> If, at the expiration of this AGREEMENT, bona fide negotiations are in progress and the PARTIES are making a good faith effort to reach agreement, the terms of this AGREEMENT shall remain in full force and effect on a month-to-month basis for a period not to exceed four (4) months unless terminated by either party without cause on 14 days written notice.

Renewal Option While the agreement may have a termination date, it can also be agreed that either or both parties automatically have the option to continue the contract. An automatic renewal of a short contract versus a long contract with a definite termination date are considerations for the health center.

Whatever option is chosen, the contract should be reviewed annually for appropriateness. Very often in longtime relationships, self-renewing contracts are disputed when the written contract varies from customary practice developed over time by the parties.

> This AGREEMENT shall be considered automatically renewed for additional one-year periods commencing the day after the expiration date set forth herein, on the same terms and conditions as set forth herein, except for changes made pursuant to paragraph x of this AGREEMENT (AMENDMENTS) if the CENTER does not receive notice of PHYSICIAN's intent to terminate at least one hundred twenty (120) days prior to the expiration date of this AGREEMENT.

Termination without Cause A contract will terminate by its own terms (see TERM OF AGREEMENT); however, sometimes a party wants to terminate the contract before its agreed upon expiration.

"Without cause" indicates that no reason must be given for ending the contract. It is customary in a termination-without-cause provision to have an adequate period of time to permit the parties to readjust to life without each other. Sixty, 90, or 120 days are common periods for terminating a contract without cause.

The clause can apply to one or both parties. For example, perhaps the parties have agreed that only the physician can terminate without cause on 120 days notice whereas the health center can terminate only with cause. Or, both parties can terminate on 90 days notice without cause.

Termination with Cause One or both parties may wish to limit a termination before the end of the contract period if the terminating party can show "good cause." The good cause can be specifically enumerated; for example, conviction of a felony or conflict of interest. Or, it may be simply and vaguely stated, "for good cause shown." In enumerating causes, the health center may want to include contract-dependent items such as "termination of funding" (see WHEREAS RECITATIONS) or management specific items such as "less than 350 patient encounters per month for three consecutive months."

The notice period for termination with cause is usually much shorter than that for termination without cause.

In cases where a continued contractual relationship would pose a threat to patient health or safety, it should be agreed that no notice need be given. Abrupt dismissal such as this should be coupled with a grievance procedure to justify the termination.

> In the event PHYSICIAN fails to perform any of the terms of this AGREEMENT, HEALTH CENTER may give written notice to PHYSICIAN that if such default is not cured within ten (10) days, the AGREEMENT shall be terminated without further notice.

> In the event immediate action must be taken in the best interest of the PATIENT due to some action or omission on the part of PHYSICIAN, HEALTH CENTER may effect immediate termination on written notice.

> In the event of involuntary termination for cause, PHYSICIAN shall be accorded all due process rights pursuant to HEALTH CENTER POLICIES.

> This AGREEMENT shall be terminated immediately and without notice on the death, certification of mental incompetency, or severe physical impairment of PHYSICIAN.

40. Including Standard Provisions

Standard clauses appearing routinely in contracts that, for the most part, are not bargaining points, follow. Their inclusion is at the discretion of the parties and their legal counsel. Some clauses are self-explanatory and are included here without comment.

Disputes Clause/Grievance Procedure If no grievance procedure exists in the personnel policies that can be alluded to in the agreement, a more specific item regarding the handling of disputes arising from the agreement can be included. In either case, due process considerations should be explored with legal counsel to be assured that adequate review of disputes, especially terminations, comply with federal and state requirements.

> Any controversy or claim arising out of or relating to this AGREEMENT shall be settled by arbitration in accordance with the rules of the American Arbitration Association, and judgment on the award rendered by the arbitrator or arbitrators may be entered in any court having jurisdiction thereof. Any party to this AGREEMENT may submit to arbitration any said controversy or claim.

> Or--

> Any dispute arising out of or relating to this AGREEMENT shall be subject to the employee grievance procedure of HEALTH CENTER'S this PERSONNEL POLICIES.

Integration To ensure that the written document carries the finality that will end negotiations and represent the full and final agreement of the parties, a standard integration clause is added. By doing so, the discussions during negotiations cannot be brought up at some future time as an additional oral agreement of the parties, especially where the terms differ from those written.

> Any prior agreements, promises, negotiations or representations either oral or written, relating to the subject matter of this AGREEMENT not expressly set forth in this AGREEMENT are of no force or effect.

> Or--

> This AGREEMENT contains all the terms and conditions agreed upon by the parties hereto regarding the subject matter of this AGREEMENT.

Confidentiality

> PHYSICIAN agrees not to communicate, divulge or use for the benefit of any person, partnership or corporation, any of the charts or records of the PATIENT of HEALTH CENTER, professional policies, manuals, instructions, reports, lists of PATIENT names, or any other confidential information of any type or description, without the written consent of HEALTH CENTER.

Modification or Amendment

> This AGREEMENT may be amended at any time by mutual agreement of the PARTIES, provided that before any amendment shall be operative or valid, it shall be reduced to writing and signed by the PARTIES.

Severability If one clause is found invalid, the entire contract is invalid and cannot be enforced by the courts. To avoid this, it is suggested that the parties clearly express their intent to maintain the other clauses in full effect should one clause be found invalid.

> The provisions of this AGREEMENT are separable. If any one or more of the provisions are held invalid by a court of competent jurisdiction or are voided or nullified for any reason, the remaining provisions and paragraphs shall continue in full force and effect and shall be binding on the parties so as to carry out the intent and purpose of PARTIES.

Construction When terms are not clear or when the courts have to make a decision about the meaning of the contract, the construction clause states that the agreement will be "construed" (hence the heading "construction") under state laws where the contract is to be performed.

> This AGREEMENT is executed and intended to be performed in the State of California, and the laws of the state shall govern in its interpretation and effect.

Waiver of Breach Sometimes the parties stray away from the terms of the contract. If done consistently over a long enough period of time, the parties by their actions may in advertently rewrite a contract term.

For example, a physician in a two-year contract agrees to take call every other weekend but never takes it for 11 months. If the health center wishes to declare the physician in breach of the contract, this language may preclude the physician from claiming that the health center waived its right to declare a breach based on that provision because it did not claim a breach the first time the physician did not take call.

> No waiver by either party of any failure of the other party to keep or perform any provision of this AGREEMENT shall be deemed to be a waiver of any preceding or succeeding breach of the same or any other provision.

CHECKLIST FOR CONTRACTS BETWEEN HEALTH CENTERS AND PHYSICIANS

This checklist will help you design contracts. All of the items that appear here need not appear in a contract. Additionally, items not on the list may be included in a contract.

___ Parties

___ Whereas recitations

- Goals and objectives of parties
- Base-line commitments

  -License
  -Board certification
  -Supervision of mid-level practitioners

___ Definitions

- Personnel policies
- Days or hours
- Patients
- Written notice
- Other items parties may wish to define

___ Compensation

- Salary
- Fringe benefits
- Percentage agreements
- Productivity/incentives
- Malpractice and other insurance
- Continuing medical education

___ Services

- Type
- Quality assurance
- Practice locations

___ Probationary period

___ Administrative services

___ Call and schedule

___ Evaluation

___ Noncompetition

- Ownership of medical records

___ Term

- Automatic renewal (evergreen)

___ Termination

- With cause
- Without cause

___ Hold Harmless

___ Standard provisions

- Disputes
- Integration
- Confidentiality
- Modification
- Severability
- Construction
- Waiver of breach

SAMPLE CONTRACT

The preceding contract inventory and sample language are only a guide to negotiations. Optimally, the agreement of the parties should be reached independent of the inventory, then checked against the inventory for completeness. It is not sufficient to string together a series of sample clauses and conclude that a well-written contract has been finalized. The sample clauses are solely illustrations of what has been and can be done.

Because a contract is a unified and integrated document, it should be drafted and refined by someone at ease with written communication and skilled at clarifying and reducing the many hours of negotiations to final agreements.

Before the document is finalized, it should be given to an attorney, if an attorney has not been engaged before this time, or to a disinterested third party whose distance gives him or her an eye for unclear or problematic language.

The contract presented here is **not** a perfect one but is included to show how all the foregoing discussion may be reduced to a few written pages in a format and style tailored to meet the needs of both the health center and physician.

PHYSICIAN SERVICES AGREEMENT
(hereafter referred to as AGREEMENT)

THIS AGREEMENT made this xx day of Xxxxx, 19xx by and between the HAPPY VALLEY HEALTH CENTER, INC., a California non-profit corporation (herein referred to as HEALTH CENTER) acting by and through its duly appointed administrator and ELIZABETH QUARTURE, M.D., an individual acting in that capacity (herein referred to as PHYSICIAN) provide as follows:

WHEREAS, HEALTH CENTER is licensed to provide medical services to the citizens residing in Happy County, California (herein referred to as SERVICE AREA) and who otherwise meet such eligibility criteria as HEALTH CENTER may from time to time establish (herein referred to as PATIENTS);

WHEREAS, PHYSICIAN is licensed to practice medicine in the State of California and is certified by the California Board of Medical Quality Assurance to supervise certified nurse midwives and is a Diplomate of the American College of Obstetrics and Gynecology;

WHEREAS, PHYSICIAN is an active member of the medical staff of Happy Heart Hospital (herein referred to as HOSPITAL) where she agrees to maintain privileges for the duration of the AGREEMENT;

WHEREAS, it is the mutual desire of HEALTH CENTER and PHYSICIAN to:

-maintain an excellent and highly-motivated medical staff, through selection of staff based solely upon professional competence and personal character, and to afford the medical staff strong incentive for the best performance for medical services by providing adequate compensation, security and opportunity for professional advancement; and,

-ensure that matters of medical practice are under the direction of PHYSICIAN; and,

-encourage improvement and advancement of professional skills and competence; and

-provide nurse midwife services to the PATIENTS.

NOW, THEREFORE, IT IS AGREED AS FOLLOWS:

1. DEFINITIONS:

DAYS: As used in this AGREEMENT, working days in which HEALTH CENTER is open to the public. DAYS specifically excludes Saturday, Sunday and holidays recognized by HEALTH CENTER as set forth in the PERSONNEL POLICIES.

DISABILITY: PHYSICIAN's inability, through physical or mental illness or other cause, to perform the convenants of this AGREEMENT.

PERSONNEL POLICIES: Policies duly adopted by HEALTH CENTER as amended and modified from time to time. Should a conflict exist between PERSONNEL POLICIES and this AGREEMENT, this AGREEMENT shall govern.

2. EFFECTIVE DATE: This AGREEMENT is effective beginning the xxth day of Xxxxx, 19xx and continues in force, as modified from time to time or terminated in accordance with the terms of this AGREEMENT.

3. COMPENSATION: In return for the services contracted for herein, PHYSICIAN shall receive a salary of $50,000 per year payable in 24 equal installments.

4. FRINGE BENEFITS: PHYSICIAN will be entitled to the following fringe benefits:

(a) All benefits set forth in the PERSONNEL POLICIES except as specifically set forth in this paragraph.

(b) 15 DAYS of paid vacation per calendar year.

(c) 5 DAYS of continuing medical education leave per calendar year plus $500 toward expenses for the purpose of attending recognized professional educational programs as approved by HEALTH CENTER.

5. SERVICES: PHYSICIAN agrees to provide general medical services including obstetrics and gynecology and emergency services to each PATIENT in accordance with the quality of medical care conforming with currently accepted medical and surgical practices.

6. CALL: PHYSICIAN agrees to be available at such time and in such locations within the SERVICE AREA as shall be necessary and practical for prompt and proper rendition thereof. Said availability is defined and quantified to include the following times, terms and conditions:

(a) Call and weekend coverage to be shared equally among the medical staff; and

(b) Participation in the medical staff and the delivery of inpatient care at HOSPITAL; and

(c) Provision of patient care within HEALTH CENTER facility 4 DAYS per week, plus inpatient and on call responsibilities, in accordance with work schedule as developed by HEALTH CENTER.

7. QUALITY REVIEW: PHYSICIAN agrees to participate in the periodic review of the quality of health services provided in a manner as set forth in the PERSONNEL POLICIES.

8. SUPERVISION: PHYSICIAN agree to supervise a certified nurse midwife to be hired by HEALTH CENTER in consultation with PHYSICIAN.

9. OUTSIDE ACTIVITY: Because of the primary obligation to HEALTH CENTER and its PATIENTS, plus restrictions imposed by malpractice insurance, PHYSICIAN will not undertake outside medical practice for compensation without the express written consent of HEALTH CENTER.

10. TEACHING, TRAINING, RESEARCH: HEALTH CENTER agrees to consent to PHYSICIAN engaging in part-time teaching, training and research not to exceed 5 hours per week. All income, compensation or renumeration for this activity will be made payable to HEALTH CENTER.

11. ADMINISTRATION: HEALTH CENTER agrees to perform or have performed all the necessary administrative, accounting, enrollment, and other functions appropriate for the administration of the HEALTH CENTER and this AGREEMENT.

12. FACILITIES: HEALTH CENTER agrees to maintain, equip, furnish, supply, and staff facilities adequate to enable PHYSICIAN to deliver the medical services contracted for herein at a location determined by HEALTH CENTER.

13. NON-INTERVENTION: HEALTH CENTER agrees to not intervene in any manner with the rendition of medical services, it being agreed that PHYSICIAN has sole responsibility therewith.

14. INSURANCE: HEALTH CENTER agrees to procure and maintain such policies of general liability and professional liability insurance, if available to insure PHYSICIAN against claim or claims for damages arising by reason of personal injuries or death occasioned directly or indirectly in connection with the performance of any professional services by PHYSICIAN, the use by PHYSICIAN of any property and facilities provided by HEALTH CENTER and the activities performed by PHYSICIAN in connection with this AGREEMENT, the aggregate of such policies shall be in limits of not less than one million/three million dollars ($1,000,000/$3,000,000) in the event of injury or death to one or more persons as a result of the same accident.

If malpractice coverage has not been provided, HEALTH CENTER agrees to reimburse PHYSICIAN for the cost of said insurance.

Should PHYSICIAN be refused insurance coverage, such loss of insurability is deemed cause for termination under the provisions of this AGREEMENT.

15. MEDICAL RECORDS: Upon termination of this AGREEMENT at any time and for any reason, the medical records of HEALTH CENTER shall be retained by the HEALTH CENTER at HEALTH CENTER facility. PHYSICIAN shall have the right to have copies made for her own use at her own expense.

16. ARBITRATION: All claims, disputes, and other matters in question arising out of or relating to this AGREEMENT or the breach thereof shall be decided by arbitration in accordance with the Commercial Arbitration Rules of the American Arbitration Association then pertaining, unless the parties mutually agree otherwise. Written determination of the arbitration shall be final and binding on the parties. If either party institutes an action to enforce any of the terms of this AGREEMENT, the prevailing party shall, in addition to any other damages, be entitled to recover its cost of suit and reasonable attorney's fees incident to such action.

17. INTEGRATION: This AGREEMENT, together with any modifications or amendments signed by the parties, comprises the complete AGREEMENT; neither of the parties has made any representation or warranty other than those set forth in this AGREEMENT and such modification or amendments.

18. INTERPRETATION: This AGREEMENT shall be construed and governed by the laws of the State of California.

19. SEVERABILITY: In the event that any portion of this AGREEMENT shall be found by a court of competent jurisdiction to be void or illegal, it shall not affect the validity or enforceability of any other portion of this AGREEMENT.

20. WAIVER OF BREACH: No waiver by either party of any failure of the other party to keep or perform any provision of this AGREEMENT shall be deemed to be a waiver of any preceding or succeeding breach of the same or any other provision.

21. NOTICE: All notices given pursuant to this AGREEMENT shall be made by mailing the same, postage paid to HEALTH CENTER or PHYSICIAN at the address set forth opposite the signature of each part, or such other address as wither may advise the other pursuant to the provisions of this AGREEMENT.

22. MODIFICATION: This AGREEMENT may be modified at any time by mutual consent of the parties. Such modification shall be in writing and signed by both parties and attached hereto.

23. TERMINATION WITH CAUSE: Notwithstanding the foregoing, PHYSICIAN may be terminated without notice upon the occurrence of any of the following:

- PHYSICIAN commission of any act, criminal or otherwise, that, in the opinion of HEALTH CENTER, might injure the professional reputation or practice of HEALTH CENTER;

- PHYSICIAN's loss of California license or malpractice insurance;

- failure of PHYSICIAN to rectify a breach of any of the terms, convenants, and conditions of this AGREEMENT within fifteen (15) days after written notice from HEALTH CENTER of such curable default;

- PHYSICIAN's death or DISABILITY;

- any act or omission which, in the opinion of HEALTH CENTER, is injurious to PATIENT health, safety or well-being.

24. TERMINATION WITHOUT CAUSE: Either party may terminate this AGREEMENT on 120 calendar days written notice.

IN WITNESS WHEREOF, HEALTH CENTER has caused this AGREEMENT to be executed and its corporate seal to be affixed by its duly authorized officers, and PHYSICIAN has executed this AGREEMENT by setting her hand as of the day and year first above written.

(seal)

ROBIN RED BREAST
Administrator
Happy Valley Health Center
711 Happy Road
Happy Valley, California

ELIZABETH QUARTURE, M.D.
123 Quail Lane
Happy Valley, California

FOR MORE INFORMATION

Health Care Executive Compensation, Principles and Strategies. Jerad D. Browdy. Aspen Publications, 1983.

Hospital Contracts Manual Aspen Publications, 1984.

Guidelines, Contractual Relationships Between Hospitals and Physicians. American Hospital Association, 1976. (pamphlet)

Win/Win Outcomes: A Physician's Negotiating Guide. Seymour J. Burrows. Pluribus Press, Chicago, 1984.

APPENDIX A

ACCREDITED PROGRAMS IN FAMILY PRACTICE IN CALIFORNIA

Bakersfield

Kern Medical Program,
Kern Medical Center
Navinchandra M Amin, MD
Program Director
Kern Medical Center
Dept. of Family Practice
1830 Flower Street
Bakersfield, CA 93305
Total Positions: 12

Camp Pendleton

Naval Hospital Program
(Camp Pendleton)
Cdr. Larry H. Johnson, MC, USN
Program Director
Naval Hospital
Dept. of Family Practice
Camp Pendleton, CA 92055
Total Positions: 29

Fairfield

David Grant USAF Medical
Center Program
Lt. Col. Warren P. Jaeger, MC
Program Director
David Grant USAF Medical Center
Dept. of Family Practice
Travis AFB
Fairfield, CA 94535
Total Positions: 27

Fontana

Kaiser Foundation Hospital Program,
Kaiser Foundation Hospital
Irvin S. Roger, MD
Program Director
Family Practice Center
9985 Sierra Avenue
Fontana, CA 92335
Total Positions: 18

Fort Ord

Silas B. Hays Army Community
Hospital Program
Thomas C. Hoffer, MD
Program Director
Silas B Hays Army Community
Hospital
USAMEDDAC
Ford Ord, CA 93941
Total Positions: 18

Fresno

University of California (San Francisco)
Program A, Valley Medical Center of Fresno
H.J. Blossom, MD
Program Director
Dept. of Family Practice
445 S. Cedar Avenue
Fresno, CA 93702
Total Positions: 24

Glendale

Glendale Adventist Medical Center Program
William D. Putnam, MD
Program Director
Family Practice Residency Program
801 S. Chevy Chase
Glendale, CA 91205
Total Positions: 24

Long Beach

Memorial Medical Center of
Long Beach Program
Richard W. Nixon, MD
Program Director
Memorial Hospital Medical Center
2701 Atlantic Avenue
Long Beach, CA 90806
Total Positions: 18

Los Angeles

Kaiser Foundation Hospital, Program,
Kaiser Permanente Medical Center (Los Angeles)
Irving Rasgon, MD
Program Director
Kaiser Foundation Hospital
4867 Sunset Blvd.
Los Angeles, CA 90027
Total Positions: 18

Martin Luther King, Jr.-Drew Medical Center
Program
Ernest Y.T. Yen, M.D.
Program Director
Center for the Health Sciences
Charles R. Drew Postgraduate
Medical School
Los Angeles, CA 90059
Total Positions: 18

Source: 1985-86 Directory of Residency Training Programs, American Medical Association c 1985, pps. 126-128. Reprinted with permission.

UCLA Hospital and Clinics,
Center for Health Sciences Program
Peter Chopivsky, MD
Program Director
Center for the Health Sciences
UCLA Medical Center
Rm B H 134
Los Angeles, CA 90024
Total Positions: 18

University of Southern California/
California Hospital Medical Center
Program
K.M. Wakefield, MD
Program Director
California Hospital Family
Health Center
1338 S. Hope Street
Los Angeles, CA 90015
Total Positions: 14

Martinez
Contra Costa County Medical
Services Program, Contra Costa
County Hospital
Jay Aiken, MD
Program Director
Contra Costa County Medical
Services
2500 Alhambra Avenue
Martinez, CA 94553
Total Positions: 20

Merced
Merced Family Practice Program,
Merced Community Medical Center
J. Edward Hugheil, MD
Program Director
Merced Community Medical Center
301 E. 13th St., PO Box 231
Merced, CA 95340
Total Positions: 15

Modesto
Scenic General Hospital Program
Norman B. Kahn, Jr., MD
Program Director
Scenic General Hospital Family
Practice Center
900 Scenic Drive
Modesto, CA 95350
Total Positions: 20

Northridge
Northridge Hospital Medical Center
Program
Myron C. Greengold, MD
Program Director
Northridge Hospital Medical Center
18406 Roscoe Blvd.
Northridge, CA 91325
Total Positions: 18

Redding
University of California (Davis)
Program B, Shasta General Hospital
Mercy Medical Center, University of
California (Davis)
Medical Center, Sacramento
Perry A. Pugno, MD, MPH
Program Director
Family Practice Center
2615 Hospital Lane
Redding, CA 96001
Total Positions: 12

Riverside
Riverside General Hospital Program,
Riverside General Hospital-University
Medical Center
Y. Paul Aoyagi, MD
Program Director
Riverside General Hospital
9851 Magnolia Avenue
Riverside, CA 92503
Total Positions: 21

Sacramento
University of California (Davis) Program A,
University of California (Davis) Medical
Center, Sacramento
Martin Mendleson, MD, PhD
Program Director
Department of Family Practice
2221 Stockton Blvd., Rm 14
Sacramento, CA 95817
Total Positions: 29

Salinas
Natividad Medical Center Program
John E. Midtling, MD
Program Director
Natividad Medical Center
Box 1611
Salinas, CA 93902
Total Positions: 18

San Bernardino
San Bernardino County Medical
Center Program
Merrill N. Werblun, MD
Program Director
San Bernardino County Medical
Center
780 E. Gilbert
San Bernardino, CA 92404
Total Positions: 54

San Diego
University Hospital, UC Medical
Center Program, UCSD Medical Center
M. Scott Willson, MD, MPH
Program Director
University Hospital-UC Medical
Center
225 Dickinson, H809
San Diego, CA 92103
Total Positions: 18

San Francisco
San Francisco General Hospital
Medical Center, (University of
California Program)
Peter S. Sommers, MD
Program Director
San Francisco General Hospital
Bldg 80, Ward 83
1001 Potero Avenue
San Francisco, CA 94110
Total Positions: 33

San Jose
San Jose Hospital Program,
San Jose Hospital
William C. Fowkes, MD
Program Director
Family Health Center
25 N. 14th St, Suite 1020
San Jose, CA 95112
Total Positions: 14

San Pedro
San Pedro Peninsula Hospital
Program
F.X. Mohaupt, MD
Program Director
Family Practice Residency Center
1300 W. 7th Street
San Pedro, CA 90732
Total Positions: 12

Santa Monica
Santa Monica Hospital Medical
Center Program
Sanford Blood, MD
1225 15th Street
Santa Monica, CA 90404
Total Positions: 22

Santa Rosa
University of California,
(San Francisco) Program B,
Community Hospital of Sonoma County
Franklyn D. Dornfest, MD
3325 Chanate Road
Santa Rosa, CA 95406
Total Positions: 28

Stockton
San Joaquin General Hospital Program
Glen E. Brown, MD
San Joaquin General Hospital
Box 1020
Stockton, CA 95201
Total Positions: 18

Torrance
Los Angeles County Harbor—
UCLA Medical Center Program
Fred Matthies, MD
Harbor County Hospital
1001 W. Carson Street, Suite E
Torrance, CA 90502
Total Positions: 14

Ventura
Ventura County Medical Center Program
Fran S. Larsen, MD
Ventura County Medical Center
3291 Loma Vista Road
Ventura, CA 93003
Total Positions: 35

Whittier
University of Southern California Program,
Presbyterian Intercommunity Hospital
L. Robert Martin, MD
Presbyterian Intercommunity Hospital
12401 E. Washington Blvd.
Whittier, CA 90602
Total Positions: 18

GEOGRAPHICAL LISTING OF MEDICAL SCHOOLS

Alabama
University of Alabama School of Medicine

University of South Alabama College of Medicine

Arizona
University of Arizona College of Medicine
1501 North Campbell Avenue
Tucson, AZ 85724
Louis J. Kettel, MD, Dean
602/626-7383

Arkansas
University of Arkansas College of Medicine

California
University of California, Davis, School of Medicine
Davis, CA 95616
Hibbard E. Williams, MD, Dean
916/752-0321

University of California, Irvine, School of Medicine
Irvine, CA 92717
Gerald Weinstein, MD, Acting Dean
714/856-5925

University of California, Los Angeles, School of Medicine
Los Angeles, CA 90024
Sherman M. Mellinkoff, MD, Dean
213/825-5851

University of California, San Diego, School of Medicine
La Jolla, CA 92093
Robert G. Petersdorf, MD, Dean
619/452-3713

University of California, San Francisco, School of Medicine
513 Parnassus Avenue
San Francisco, CA 94143
Rudi Schmid, MD, Dean
415/666-2342

Charles R. Drew Postgraduate Medical School
1621 E. 120th Street
Los Angeles, CA 90059
M. Alfred Haynes, MD, Dean
213/603-3001

Loma Linda University, School of Medicine
Loma Linda, CA 92350
G. Gordon Hadley, MD, Dean
714/824-4462

University of Southern California School of Medicine
2025 Zonal Avenue
Los Angeles, CA 90033
Joseph P. Van der Meulen, Acting Dean
213/224-7001

Stanford University School of Medicine
Stanford, CA 94305
David Korn, MD, Dean
415/497-6436

Colorado
University of Colorado School of Medicine
4200 East Ninth Avenue
Denver, CO 80262
Joseph W. St. Geme, Jr., MD, Dean
303/394-7565

Connecticut
University of Connecticut School of Medicine

Yale University School of Medicine

Source: The Directory of American Medical Education, 1985-86, published by the Association of American Medical Colleges. Copyright 1985.

District of Columbia
George Washington University School of Medicine and Health Sciences

Georgetown University School of Medicine

Howard University College of Medicine

Florida
University of Florida College of Medicine

University of Miami School of Medicine

University of South Florida College of Medicine

Georgia
Emory University School of Medicine

Medical College of Georgia School of Medicine

Mercer University School of Medicine

Morehouse School of Medicine

Hawaii
University of Hawaii John A. Burns School of Medicine
1960 East-West Road
Honolulu, HI 96822
Terrence Rogers, PhD, Dean
808/948-8287

Illinois
University of Chicago, Division of Biological Science, The Pritzker School of Medicine

University of Health Sciences/Chicago Medical School

University of Illinois College of Medicine

Loyola University of Chicago Stritch School of Medicine

Northwestern University Medical School

Rush Medical College of Rush University

Southern Illinois University School of Medicine

Indiana
Indiana University School of Medicine

Iowa
University of Iowa College of Medici

Kansas
University of Kansas Medical Center, School of Medicine

Kentucky
University of Kentucky College of Medicine

University of Louisville School of Medicine

Louisiana
Louisiana State University, School of Medicine in New Orleans

Louisiana State University School of Medicine in Shreveport

Tulane University School of Medicine

Maryland
John Hopkins University School of Medicine

University of Maryland School of Medicine

Uniformed Services University of the Health Sciences, F. Edward Hebert School of Medicine

Massachusetts
Boston University School of Medicine

Harvard Medical School

University of Massachusetts Medical School

Tufts University School of Medicine

Michigan
Michigan State University
College of Human Science

University of Michigan
Medical School

Wayne State University School
of Medicine

Minnesota
Mayo Medical School

University of Minnesota-
Duluth School of Medicine

University of Minnesota
Medical School-Minneapolis

Mississippi
University of Mississippi
School of Medicine

Missouri
University of Missouri-
Columbia School of
Medicine

University of Missouri-
Kansas City School of
Medicine

Saint Louis University School
of Medicine

Washington University School
of Medicine

Nebraska
Creighton University School
of Medicine

University of Nebraska
College of Medicine

Nevada
University of Nevada School
of Medicine
Savitt Medical Sciences Bldg.
Reno, NV 89557-0046
Robert M. Dougherty, Jr.,MD, PhD
Dean
702/784-6001

New Hampshire
Dartmouth Medical School

New Jersey
University of Medicine and
Dentistry of New Jersey, New Jersey
Medical School

University of Medicine and
Dentistry of New Jersey,
Rutgers Medical School

New Mexico
University of New Mexico
School of Medicine
Albuquerque, NM 87131
505/277-2321 (Dean's office)

New York
Albany Medical College of
Union University

Albert Einstein College of
Medicine of Yeshiva University

Columbia University College of
Physicians and Surgeons

Cornell University Medical
College

Mount Sinai School of
Medicine of the City
University of New York

New York Medical College

New York University School
of Medicine

University of Rochester School
of Medicine and Dentistry

State University of New York
at Buffalo, School of Medicine

State University of New York,
Downstate Medical Center,
College of Medicine

State University of New York
at Stony Brook, Health
Sciences Center,
School of Medicine

State University of New York, Upstate Medical Center at Syracuse, College of Medicine

North Carolina
Bowman Gray School of Medicine of Wake Forest University

Duke University School of Medicine

East Carolina University School of Medicine

University of North Carolina at Chapel Hill, School of Medicine

North Dakota
University of North Dakota School of Medicine

Ohio
Case Western Reserve University School of Medicine

University of Cincinnati College of Medicine

Medical College of Ohio at Toledo

Northeastern Ohio Universities College of Medicine

Ohio State University College of Medicine

Wright State University School of Medicine

Oklahoma
University of Oklahoma College of Medicine

Oral Roberts University School of Medicine

Oregon
Oregon Health Sciences University School of Medicine
3181 S.W. Sam Jackson Park Road
Portland, OR 97201
John W. Kendall, MD, Dean
503/225-8220

Pennsylvania
Hahnemann University School of Medicine

Jefferson Medical College of Thomas Jefferson University

Medical College of Pennsylvania

Pennsylvania State University College of Medicine

University of Pennsylvania School of Medicine

University of Pittsburgh School of Medicine

Temple University School of Medicine

Puerto Rico
Ponce School of Medicine
University of Puerto Rico, School of Medicine

University of Puerto Rico School of Medicine

Universidad Central del Caribe, School of Medicine

Rhode Island
Brown University Program in Medicine

South Carolina
Medical University of South Carolina College of Medicine

University of South Carolina School of Medicine

South Dakota
University of South Dakota School of Medicine

Tennessee
East Tennessee State University Quillen - Dishner College of Medicine

Meharry Medical College School of Medicine

University of Tennessee College of Medicine

Vanderbilt University School of Medicine

Texas
Baylor College of Medicine

Texas A&M University College of Medicine

Texas Tech University, Health Sciences Center, School of Medicine

University of Texas Southwestern Medical School at Dallas

University of Texas Medical School at Galveston

University at Texas Medical School at Houston

University at Texas Medical School at San Antonio

Utah
University of Utah School of Medicine

Vermont
University of Vermont, College of Medicine

Virginia
Eastern Virginia Medical School

Virginia Commonwealth University, Medical College of Virginia, School of Medicine

University of Virginia, School of Medicine

Washington
University of Washington, School of Medicine

West Virginia
Marshall University School of Medicine

West Virginia University School of Medicine

Wisconsin
Medical College of Wisconsin

University of Wisconsin Medical School

PROFESSIONAL JOURNALS THAT HAVE CLASSIFIED ADS

American Family Physician

Russell Johns Associates
Box 1510
Clearwater, FL 33517
(800) 237-9851
(813) 443-7666

.Monthly. $70 for 20 words or less plus $2.75 for each additional word. Ad copy and payment must be received no later than the 20th of the second preceding month. (e.g. for July issue, no later than May 20)

American Journal of Obstetrics and Gynecology

CV Mosby Company
11830 Westline Industrial Drive
St. Louis, MO 63146
(800) 325-4177, ext. 305

.Semimonthly. Smallest ad is a quarter page display ad for $500. Ad copy and payment must be received one month before, on the 1st or 15th.

American Journal of Public Health

Classified Advertising Department
1015 15th Street, NW
Washington, DC 20005
(202) 789-5600

.Monthly. $5 per line (35 characters per line). Copy due the first day of the second preceding month.

Journal of the American Medical Association

Classified Advertising Department
535 N. Dearborn Street
Chicago, IL 60611
(312) 280-7190

.Four issues a month; published Fridays. $12.60 per line, about 6 words/line. Minimum ad is 5 lines. Ad must be received 30 days prior to the issue date.

Journal of Family Practice

Classified Advertising Department
Appleton - Century - Crofts
25 Van Zant Street
E. Norwalk, CT 06855
(203) 838-4400

.Monthly. $90 per column inch. Minimum is one inch. Each column inch measures ten typed lines deep with about 42 characters, including spaces, per line. Add copy and payment must be received by the 10th of the month prior to the month of publication.

Medical Economics

Classified Advertising Department
Medical Economics
680 Kinderkamack Road
Oradell, NJ 07649
(201) 262-3030

.Semimonthly. Line rates are $18 per line or part of line. Approximately 52 characters per line. Minimum line ad is $90. Display ad is $225 per inch; minimum display ad is one inch.

New England Journal of Medicine

Classified Advertising Department
1440 Main Street
Waltham, MA 02254-0803

.Weekly. $3 per word. Ad copy and payment must be received 17 days before publication date.

New Physician

Classified Advertising
The New Physician
1910 Association Drive
Reston, VA 22091

.Monthly, except for combined issues for January/February, May/June and July/August. $6 per line or fraction of line. Five line minimum. Approximately 35 characters per line. Display ads (classified in a ruled panel) for an additional $35 above per line rate. The maximum size for a display ad is four inches minimum over inch. Copy must be received the first of the month preceding the month of publication.

Pediatrics

Pediatrics Classified
American Academy of Pediatrics
P.O. Box 72099
Chicago, IL 60690-2099

.Monthly. 30 words or less, $65 for an ad. Over 30 words, add $1 for each word. Copy due the first of the second month preceding the issue.

APPENDIX D

CALIFORNIA'S MEDICAL SOCIETIES

***Alameda-Contra Costa Medical Association**
William N. Guertin, Executive Secretary
6230 Claremont Avenue
Oakland, California 94618
(415) 654-5383

Butte-Glenn Medical Society
Geri Pitman, Executive Director
601 Wall Street (95926)
P.O. Box 2267
Chico, California 95927
(916) 342-4296

Forty-First Medical Society
Robert M. Garrick, Administrative Director
233 South Euclid Avenue
Pasadena, California 91101
(818) 577-0470

***Fresno-Madera Medical Society**
Mark Covington
Executive Director
P.O. Box 31 (93707)
3425 North First Street
Fresno, California 93726
(209) 224-4224

Humboldt-Del Norte County Medical Society
Penny Vogel, Executive Director
P.O. Box 6457
3100 Edgewood Road
Eureka, California 95501
(707) 442-2367

Imperial County Medical Society
Charles LePere, Executive Secretary
501 W. Olive Road
El Centro, California 92243
(619) 352-1662

Inyo-Mono County Medical Society
Donald G. Mode, MD, President
P.O. Box 1296
621 W. Line Street, Suite 107
Bishop, California 93514
(619) 872-1201

***Kern County Medical Society**
Rose M. Tessandori
Executive Director
1830 Truxton Avenue, Suite 218
Bakersfield, California 93301
(805) 325-9025

Kings County Medical Society
Marilyn Rush, Executive Secretary
P.O. Box 1029
Hanford, California 93232-1029
(209) 582-6793

Lassen-Plumas-Modoc-Sierra County Medical Society
Barbara Burton, Executive Secretary
P.O. Box 766
Chester, California 96020
(916) 258-3191

***Los Angeles County Medical Association**
Frank Clark, Executive Vice President
1925 Wilshire Boulevard
Los Angeles, California 90057
(213) 483-1581

Marin Medical Society
Peggy Page, Executive Director
4460 Redwood Highway, Suite 10
San Rafael, California 94903
(415) 479-5230

Mendocino-Lake County Medical Society
Joyce Gay, Executive Director
P.O. Box 1030
216 West Henry
Ukiah, California 95482
(707) 462-1694

Merced-Mariposa County Medical Society
Chris Tomford, Executive Secretary
2831 North G Street
Merced, California 95340
(209) 723-2976

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*These societies publish monthly bulletins which carry classified ads.

Monterey County Medical Society
Edgar H. Colvin, Executive Director
P.O. Box 80308 (93912)
19040 Portola Drive
Salinas, California 93908
(408) 455-1833 or (408) 373-4197

Napa County Medical Society
Curt Searcy, Executive Director
2700 Indiana Street
P.O. Box 2158
Napa, California 94558
(707) 255-3622

Orange County Medical Association
John J. Rette, Executive Director
P.O. Box 1297
300 South Flower Street
Orange, California 92668
(714) 978-1770

Placer-Nevada County Medical Society
Marjorie Laster, Administrative Assistant
1230 High Street, Room 211
Auburn, California 95603
(916) 885-3951

***Riverside County Medical Association**
C.P. Rowlands, Executive Director
3993 Jurupa Avenue
Riverside, California 92506
(714) 686-3342

***Sacramento-El Dorado Medical Society**
William E. Dochterman
Executive Director
5380 Elvas Avenue
Sacramento, California 95819
(916) 452-2671

San Benito County Medical Society
Josie Sanchez, Staff
911 Sunset Drive
Hollister, California 95023
(408) 637-5711

San Bernardino County Medical Society
Wm. S. Henderson, Jr., Vice President
P.O. Box 1500
952 S. Mt. Vernon Avenue
Colton, California 92324-0998
(714) 825-6526

***San Diego County Medical Society**
David Knetzer, Executive Director
P.O. Box 23015
3702 Ruffin Road
San Diego, California 92123
(619) 565-8888

***San Francisco Medical Society**
Susan B. Waters, Executive Director
P.O. Box 18719
250 Masonic Avenue
San Francisco, California 94118
(415) 567-6230

San Joaquin County Medical Society
Michael A. Monnich, Executive Secretary
P.O. Box 230 (95201)
110 West Weber Avenue
Stockton, California 95202
(209) 948-1334

San Luis Obispo County Medical Society
Karen M. Beckwith, Executive Secretary
P.O. Bo 319 (93406)
1010 Murray Avenue
San Luis Obispo, California 93401
(805) 544-3020

San Mateo County Medical Society
Robert D. Hahn, Executive Director
3080 La Selva
San Mateo, California 94403
(415) 574-3116

***Santa Barbara County Medical Society**
Sondra K. Davies, Executive Director
5350 Hollister Avenue, Suite A-4
Santa Barbara, California 93111
(805) 683-5333

***Santa Clara County Medical Society**
Howard W. Pearce, Executive Director
700 Empey Way
San Jose, California 95128
(408) 998-8850

Santa Cruz County Medical Society
Edgar H. Colvin, Executive Director
P.O. Box 80308
Salinas, California 93912
(408) 688-6404

***Shasta-Trinity County Medical Society**
Michael G. Arnold, Executive Director
P.O. Box 959
Redding, California 96099
(916) 241-6834

Siskiyou County Medical Society
Richard A. Johnson, MD, President
202 Lawrence Lane
Yreka, California 96097
(916) 842-6181

Solano County Medical Society
Alice C. Bell, Executive Director
773 Tuolumne Street
Vallejo, California 94590
(707) 642-9202

***Sonoma County Medical Association**
Gene Scott, Executive Vice President
3033 Cleveland Avenue
Santa Rosa, California 95401
(707) 544-2010

Stanislaus County Medical Society
Paul O. Humbert, Jr., Executive Director
2339 St. Paul's Way
P.O. Box 6007
Modesto, California 95355
(209) 527-1704

Tehama County Medical Association
Sanford C. Wise, Executive Secretary
210 Ash Street
Red Bluff, California 96080
(916) 527-7082

Tulare County Medical Society
Laura Strantz, Executive Director
3333 S. Fairway
Visalia, California 93277
(209) 627-2262

Tuolumne County Medical Society
Gail Gee, Executive Secretary
1 Forest Road
Sonora, California 95370
(209) 532-4843

Ventura County Medical Society
Riley McWilliams, Executive Director
625 E. Santa Clara Street
Ventura, California 93001
(805) 656-3407

***Yolo County Medical Society**
Nancy N. Thomas, Medical Executive
502 Mace Boulevard, Suite 12
Davis, California 95616
(916) 753-3000

Yuba-Sutter-Colusa County Medical Society
Edgar Ebey, Executive Secretary
P.O. Box L
320 G Street
Marysville, California 95901
(916) 673-6894

California House Officer Medical Society
Mary Bobay, Administrative Director
44 Gough Street
San Francisco, California 94103-1233
(415) 863-5522

APPENDIX E

GEOGRAPHICAL LISTING OF COLLEGES OF OSTEOPATHIC MEDICINE*

California
College of Osteopathic Medicine of the Pacific
309 Pomona Mall, East
Pomona, CA 91766
Jerry Bailes, DO, Dean of Academic Affairs
714/623-6116

Florida
Southeastern College of Osteopathic Medicine
1750-60 Northeast 168th Street
North Miami Beach, FL 33162
Arnold Melnick, DO, Dean
(305) 949-4000

Illinois
Chicago College of Osteopathic Medicine
5200 South Ellis Avenue
Chicago, IL 60615
Thomas W. Allen, DO, Dean
(312) 947-3000

Iowa
College of Osteopathic Medicine and Surgery
3200 Grand Avenue
Des Moines, Iowa 50312
Joseph A. Walsh, DO, Dean for Academic Affairs
(515) 271-1400

Maine
New England College of Osteopathic Medicine
University of New England
Biddeford, Maine 04005
Jack S. Ketchum, MDA, President
(207) 283-0170

Michigan
Michigan State University/College of Osteopathic Medicine
East Free Hall
East Lansing, Michigan 48824
Myron S. Magen, DO, Dean
(517) 355-9611

Missouri
Kirksville College of Osteopathic Medicine
204 West Jefferson
Kirksville, Missouri 63501
James R. Stookey, DO, Dean of Academic Affairs
(816) 283-2000

The University of Health Sciences/College of Osteopathic Medicine
2105 Independence Boulevard
Kansas City, Missouri 64124
Leonard Mennen, DO, Dean for Academic Affairs
(816) 283-2000

New Jersey
College of Medicine and Dentistry of New Jersey
New Jersey School of Osteopathic Medicine
300 Broadway
Camden, New Jersey 08103
Benjamin L. Cohen, DO, Dean
(609) 868-7788

New York
New York College of Osteopathic Medicine
New York Institute of Technology
Wheatley Road, Box 170
Old Westbury, Long Island, NY 11568
Philip Fleisher, DO, Dean/Provost for Medical Affairs
(516) 686-7788

Source: Directory of Osteopathic Physicians and Surgeons, 1983-84. Board of Osteopathic Examiners of the State of California.

*Accredited by the American Osteopathic Association and approved by the California Board of Osteopathic Examiners.

Ohio
University College of Osteopathic Medicine
Grosvenor Hall
Athens, Ohio 45701
Frank W. Myers, DO, Dean
(614) 594-6401

Oaklahoma
Oklahoma College of Osteopathic Medicine & Surgery
1111 West 17th Street
P.O. Box 2280
Tulsa, Oklahoma 74101
John Rutherford, DO, Dean for Academic Affairs
(918) 582-1972

Pennsylvania
Philadelphia College of Osteopathic Medicine
4150 City Avenue
Philadelphia, Pennsylvania 19131
Robert W. England
(215) 581-6000

West Virginia
West Virginia School of Osteopathic Medicine
400 North Lee Street
Lewisburg, West Virginia 24901
Kirk Herrick, DO, Dean for Academic Affairs
(304) 645-6270

APPENDIX F

STATE MEDICAL ASSOCIATIONS IN THE UNITED STATES*

Alabama
Medical Association of State
Alabama
S. Lon Conner
Executive Director
P.O. Box 1900-C
Montgomery, AL 36197

Alaska
Alaska State Medical Association
Martha MacDermaid
Executive Secretary
4107 Laurel St., Suite 1
Anchorage, AK 99508

Arizona
Arizona Medical Association
Bruce E. Robinson
Executive Vice President
810 W. Bethany Home Road
Phoenix, AZ 85103

Arkansas
Arkansas Medical Society
C.C. Long, MD
Executive Vice President
P.O. Box 1208
Ft. Smith, AR 72902

Kenneth L. LaMastus
Assistant Executive Vice
President
Plaza West 750
415 N. McKinley
Little Rock, AR 72205

California
California Medical Association
Robert H. Elsner
Executive Vice President
44 Gough Street
San Francisco, CA 94103

Colorado
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